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INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL

INSTRUCTOR GUIDE

Department of Health and Human Services
Public Health Service
Centers for Disease Control
Center for Prevention Services
Division of Tuberculosis Control
Atlanta, Georgia 30333

ga | CDC

COMPLETED

ORIGINAL

FOREWORD

INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL is a response to requests from numerous tuberculosis control officers and program managers across the country for a training course for staff whose responsibilities include interviewing patients, performing outreach activities, and assuring patients' compliance with medical recommendations. This course is representative of our continuing commitment to assist States and localities in efforts to prevent, control, and eliminate tuberculosis in the United States.

The first steps in developing the course were taken in 1985, and since then, many people have devoted considerable time, energy, and support to creating the finished product contained in this binder. H. Mack Anders of our Program Services Branch is the principal author of the course. He has dedicated countless hours to research, writing the Instructor Guide and Participant Guide, and coordinating the work of others during the development, field testing, and final production phases. Wendy Cuneo, our public health education specialist, has worked very closely with Mack on the instructional design of the course and in editing the text. The course is action-oriented, and both Mack and Wendy's diligent work to ensure that participants are truly involved in the learning process will become apparent in the classroom. Russ Havlak and Albert Brasile of the Division of Sexually Transmitted Diseases shared ideas and material with us for which we are grateful. We are indebted to Dr. Bapu Arekapudi, John Kuharik, and the staff in Chicago and to Dr. Donald Williamson, Joe Greene, and the staff in Alabama for allowing us to field test earlier versions of the course in their areas. We are grateful to the tuberculosis controllers in California, Missouri, South Carolina, and Virginia and especially to Jeffery Nugent (CA), Bernard Malone (MO), Carol Pozsik (SC), and Russell Hansen and Lex Gibson (VA) for premiering the course in early 1987. The feedback they gave us based on their experiences in planning and teaching the course was immensely valuable in producing our final materials. We thank Joyce Ayers and James Pledger, Technical Information Services, Center for Prevention Services for their unfailing support in editing and printing and in creating the cover design. Sharon Dickerson-Eke, Elaine Neuhaus, and Andrea Moore contributed time and talent to word processing, and we thank them. Finally, to all the other unnamed persons who reviewed drafts, made suggestions, participated in the field tests and premieres, and contributed in countless other ways, we are deeply appreciative.

All of us who have been involved in developing INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL sincerely hope that it will help you meet tuberculosis training needs in your program. We trust that it will also be a pleasant and productive experience for you and your class.

Dixie E. Snider, Jr., M.D., M.P.H.
Director
Division of Tuberculosis Control
Center for Prevention Services
Centers for Disease Control

Instuctor Orientation

II

INSTRUCTOR ORIENTATION

DHHS:PHS:CDC:CPS:DTBC:9/87

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ORIENTATION FOR THE INSTRUCTOR

INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL was developed by the Division of Tuberculosis Control, Center for Prevention Services, Centers for Disease Control (CDC). It is designed to be taught at the State and local levels by supervisory tuberculosis or other appropriate health department personnel. The purpose of the course is to improve the knowledge and job skills of health department staff who have tuberculosis interviewing, investigating, and compliance influencing responsibilities. It should be considered as only one part of staff training and development. Since staff to be trained may belong to various personnel classifications, we use "TB health care providers" throughout the materials to designate persons who work with tuberculosis clients.

This binder contains the two primary texts: the *Instructor Guide* and the *Participant Guide*. It will be necessary for you to reproduce the *Participant Guide* for distribution to persons enrolled in the course. A camera-ready copy is located at the last tab.

The *Instructor Guide* provides the information and material you need to teach the course. Teaching techniques involve instructor presentations, group discussions, practice interviews, role playing exercises, and use of videotapes. Both the *Instructor Guide* and the *Participant Guide* contain reading material which is essential for each session. It is important for you to be thoroughly familiar with the material in both guides. We recommend that instructors have a minimum of three years' experience in tuberculosis control. Every effort should be made to tie every aspect of this course to the practical, day-to-day world of tuberculosis control.

Outside readings in the *Participant Guide* are an integral feature of the course. The reading assignments are not extensive, and participants should be required to complete them before attending classes in which the topics will be covered. Participants should be encouraged to take an active part in the discussions and other classroom activities. They can best do this if they have read the material in advance. It is important for participants to have had instruction in tuberculosis prior to taking this course. CDC's TUBERCULOSIS MEDICAL ORIENTATION COURSE is an ideal prerequisite.

The course is divided into three parts so that instruction may be targeted to specific staff training needs. "Part I, Basic Concepts," contains preparatory material, such as principles of communication and assertiveness, which is essential for both of the other parts. "Part II, Interviewing," deals with the skills of interviewing patients and suspects. "Part III, Field Investigation," focuses on outreach activities of TB health care providers in the community. Staff members who have responsibilities for interviewing *and* field work should take the entire course. Persons who interview patients and suspects but do not work in the field should take Parts I and II. Persons who work in the field but do not have interview responsibilities should take Parts I and III. You need to know the job functions of participants as well as their current skill levels in order to adapt the course to meet their unique training needs.

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The entire course covers three days of classroom activities. Parts I and II only require two days, and Parts I and III only require two days. The course should be taught on consecutive days; however, if scheduling is a problem, it may be taught on selected days over a period of several weeks.

The three parts are divided into component sessions. Each session is important to participants' learning new or improved techniques of interviewing, investigating, and influencing compliance. The sessions are reflected in the timetables which are included in this orientation section. The timetables correspond to the various options for presenting the course: Parts I, II, and III; Parts I and II; and Parts I and III. These timetables may be extended, if necessary, to meet the special needs of participants, e.g., to allot time to discuss related local policies and procedures. We strongly recommend that the content for the parts you are teaching not be shortened.

Each of the sessions has specific objectives to guide participants in their learning experience. There are also two tests: a Pre-course Knowledge Assessment and a Post-course Knowledge Assessment. These tests will enable you and the participants to measure their increased knowledge.

We welcome your comments and suggestions. Evaluations from the field will be very helpful in improving the course and will assist us in our efforts to meet current and future needs for assistance in training tuberculosis control staff. We ask that you take a few minutes to complete and return to us the "Report of Division of Tuberculosis Control Training Course" form. A supply of forms is included at the "Instructor's Report" tab. The completed form should be mailed within 10 days of concluding the course to:

Program Services Branch
Division of Tuberculosis Control
Center for Prevention Services
Centers for Disease Control
Atlanta, Georgia 30333

INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL requires a major commitment of the instructor. The successful outcome of a course offering, as measured by increased knowledge and skills of participants, is directly related to the instructor's pre-course planning, preparation to teach, and performance in the classroom. The Instructor Guide has been written and formatted to make your job as easy as possible. The following paragraphs contain important information to help you plan and teach this course.

1. Become familiar with the Instructor Guide which comprises the bulk of the contents of this binder. The sessions are designated by sequential tab dividers. Lesson plans for each session are provided. The lesson plan is a running schedule for the session with notes for what needs to be done and said. This is your personal lecture outline; key discussion questions are included. The first page for each session tells you how much time to allot, the materials and equipment you need, suggested and required reading for participants, and the objective(s). The other pages are in a "T"

V

format. On the left side of the "T" are "things to do," such as using the flip chart, initiating an exercise, and calling on participants. On the right side of the "T" are "things to say." Material which is to be transferred onto a flip chart is designated by ▭ . This is a basic lesson plan outline and may not include everything you want or need to say in class. Add to the basic plan as appropriate. Always be prepared with more material than it appears you need; know in advance what part(s) you will delete if time runs out. A sample lesson plan format is included which you may reproduce and use to develop your own personal lesson plans.

2. The course involves each participant in group exercises, role plays, practice sessions, and discussions. To ensure involvement of participants in these activities and obtain the benefits of group dynamics, a class of 10 - 16 is ideal. Try to enroll an even number of participants, because many of the role plays and exercises are performed in dyads.

3. At least two weeks prior to scheduled training dates, send a letter confirming enrollment, a copy of the course description, and a Participant Guide to each person accepted. You will have to reproduce the Participant Guide from the camera ready copy provided in this binder. Guides should be hole punched to fit into a binder or cover, if one can be provided. It is not necessary to mail the binder. The letter should emphasize that the assigned reading must be completed before the classroom session in which that material is to be covered. It is a good idea to ask participants to read the entire Guide before arriving. The maximum benefits of each class session will be realized only if each participant has read the material, is acquainted with the learning objective(s), and is prepared to engage in discussions, role plays, practice interviews, and other classroom activities.

4. Prepare a specific agenda for your course. This may be sent to participants in advance (with your letter) or handed out on the first day.

5. Prepare a list of participants and their duty stations to hand out on the first day. Include the name, location and dates of the course, and the instructors' names. Use your list to call on participants by name. Checking off the names of participants as they answer a question, or otherwise make a contribution to the class, is also a way to keep track of which participants have already become involved in the discussions and which ones can be encouraged to do so. Have large cards and markers available on the first day so that participants can make name tents to place on the table in front of them. Their names should be printed on both sides.

6. Reproduce copies of the handouts for each of your participants. Camera-ready copies are provided for you behind the next tab.

7. Make arrangements to have videotaping and playback equipment in the classroom for the interview sessions. Many health departments have such equipment. Check with the audiovisual section of your health department. It is best to have someone other than a participant or lead instructor operate the video camera.

8. There should be at least two instructors. This adds variety in the classroom and keeps one person from having to bear the entire teaching responsibility. Clarify for all instructors in advance what sessions(s) they are to prepare for and teach.

9. If possible, appoint a support person (not a participant) to assist you before and during the course. A role for this person, among others, is to act as a timekeeper. It is important for you to keep to the time schedule of the lesson plan. The support person can let you know 10 minutes before each deadline that your time for that segment of the lesson plan is nearly finished.

10. It is helpful to have the other instructor(s) sit in the class to act as an observer and note which parts of the teaching and class process have been most successful and which parts could be improved. This critique by a colleague may be done throughout the course, but is most helpful at the beginning so that necessary adjustments can be made as early as possible. The "observing" instructor should sit at the table with participants.

11. Participants (and instructors) should be reminded to speak loudly and distinctly.

12. The presentations and discussions should be free of jargon and terms which may be beyond the level appropriate for the particular group. However, proper use of the basic terms used in tuberculosis control is encouraged.

13. To facilitate discussion sessions, when a participant asks a question, you should repeat it (or rephrase it, if necessary) and call on someone else in the class to answer.

14. It is important not to let a factual error in a participant's answer go uncorrected. Even if only a small point in an otherwise correct answer is wrong, that point should quickly be clarified so that others in the class will not be left with an incorrect impression.

15. Use of the chalk board or flip chart is essential. It is best to avoid writing down complete definitions or long summaries. Key words, or an outline of points central to a discussion or presentation, are most helpful. Large writing will permit even those in the back of the class to see the material clearly. A corner of the board or separate pages from the flip chart (pinned or taped to the walls) can be used to keep track of points that arise which should be covered again later or that are needed for future reference. To save time in class, transfer material from the lesson plan to flip chart pages in advance.

16. All of the course material should be covered in class. The depth and completeness with which it is covered may vary according to the background and experience of the participants. For some groups, issues which go beyond the basic material may also be addressed. However, it is important to cover all the basic information before adding new material.

17. Participants who successfully complete the course may be awarded a training certificate. The name of the participant, course title, location, and dates should be shown on the certificate.

18. The pages that follow contain additional specific information and suggestions to help you. Included are a course description, sample enrollment letter, classroom arrangement, materials and equipment, sample lesson plan format, and timetables.

CDC staff are available to provide consultation and assistance to you. You may contact your Program Management Consultant by mail or telephone at:

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Center for Prevention Services
Centers for Disease Control
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404-329-2508
FTS 236-2508

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INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL

COURSE DESCRIPTION

WHO IS THIS COURSE FOR?

This course is tailor-made for health department staff who have tuberculosis responsibilities for: 1) Interviewing patients and suspects; 2) conducting field investigations; and 3) influencing compliance with treatment recommendations. The course assumes that participants already have background and training in the fundamentals of tuberculosis control.

WHAT WILL BE COVERED IN THE COURSE?

Since interviewing, investigating, and influencing compliance are vital components of the tuberculosis control program, the focus of this course is on the actual skills that are required to accomplish tuberculosis program objectives. Participants will review principles of effective communication and will learn how to be persuasive, how to engender trust, how to collect complete information, how to approach and work through problems, and how to encourage clients to be active in their own treatment and recovery.

WHAT WILL PARTICIPANTS BE EXPECTED TO DO?

Participants will be asked to: 1) Do homework in the form of preparatory reading; 2) be an active member of the class; and 3) seek ways to bridge the gap between the lectures, exercises, and discussions and the real people, problems, and opportunities in the day-to-day operations of a tuberculosis control program. There will be lectures, group discussions, role playing exercises using realistic tuberculosis case studies, practice interviews, and videotaping sessions. Pre- and post-course tests, self-assessments, and feedback forms will be administered so that participants will be able to gauge their own progress in the course.

HOW CAN I BEST PREPARE FOR THIS COURSE?

Take a few minutes and list the activities that you perform that are part of interviewing patients and suspects, conducting field investigations, and influencing compliance. Identify one or two problems or thorny issues that continue to be dilemmas for you, your clients, or your tuberculosis control program. You will have an opportunity during this course to talk about your problems/issues and to hear from people who do the same kind of work. We will share ways to solve these very important but challenging dilemmas.

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SAMPLE ENROLLMENT LETTER

(Date)

(Name of participant)
(Address)

Dear ____________________:

I am pleased to confirm your enrollment in the Centers for Disease Control training course INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL which will be held from ____day/date____ to ____day/date____ at ____specific site____ in ____city and State____. The first classroom session will begin promptly at ____time____ on ____date____. The course will end at approximately ____time____ on ____date____.

Enclosed is a copy of the course description and a Participant Guide. The Guide is your primary text; bring it with you to class. Please review the entire contents before arriving. (See note below.) The Guide contains important information for each class session. Be certain to complete the assigned reading before the classroom session in which that material is to be covered. You will get the most out of the course only if you have read the material, are acquainted with the learning objectives, and are prepared to participate in discussions, role plays, practice interviews, and other classroom activities.

(The remainder of the letter can be devoted to other appropriate matters, e.g., details about lodging, travel, expense reimbursement, emergency message telephone number during class hours, etc.)

I look forward to your participation in INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL.

Sincerely yours,

____

Note: If the course is only going to cover Parts I and II, for example, be sure to indicate which pages are to be reviewed.

ARRANGEMENT OF CLASSROOM

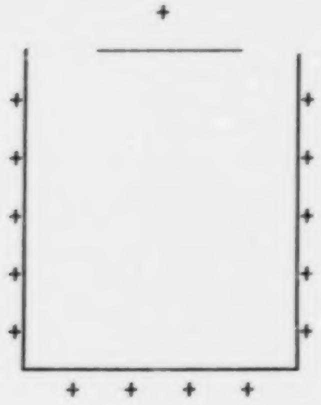
Arrange tables end to end in a "U" shape (FIG. I) with the opening of the "U" at the front of the classroom. Provide chairs for participants around the outside of the "U". Place a few extra chairs at the table for instructors and your support person. Be certain to give each participant enough space to work from an open notebook and use resource materials. There should be no extra chairs in the room. Chairs around the walls invite passive observation by persons not enrolled, and this can have a negative effect on group interaction. If you expect to have a supervisor or coworker "sit in" for part(s) of the course, invite them to join participants at the table and become an active part of the class.

Place a table at the front of the classroom for the instructor. Use this table also for the interview demonstration and videotaping sessions. The "U" should remain open to permit the instructor to move about freely in the classroom.

The space in the front of the room should be large enough to accommodate the flip chart easels, overhead projector, video playback machine and monitor, and other training equipment. The room itself needs to be large enough to position a video camera and taping equipment.

A table at the side of the room is useful for arranging and storing materials, e.g., handouts, transparencies, videotapes, and supplies.

FIG. I



MATERIALS AND EQUIPMENT

This checklist includes the essential supplies and equipment that you will need. There may be other items that you will want to include. Arrange the materials on a table at the side of the classroom so they will be readily available to you.

Binders for Participant Guides (Note: Binders are not essential; however, they do help participants organize material. Loose leaf ring binders are best. If you do provide binders, give them to participants on the first day and have them insert their guides.)

Name tags

Cards (8" x 10" or larger) for name tents

Note paper, pens, and pencils

Chalk board

Chalk

Easels (2) with flip chart paper

Marking pens

Masking tape

Handouts (see list)

1 bottle (or facsimile) each of INH, RIF, and PZA

1 sputum collection/mailing kit

Stopwatch or timer

Video camera and recorder

Video playback machine and monitor

Blank video cassettes

Certificates

Many instructors like to use an overhead projector and acetate to highlight lectures. We suggest you use them to augment, not replace, the flip chart. Although transparencies are not provided with the course material, numerous pages , such as Principles of Verbal Communication and Principles of Listening, are suitable for conversion to transparencies. Use these techniques if you feel comfortable with them and if they will enhance your presentations. You will need the following optional equipment and materials: Overhead projector and screen, acetate and marking pens, and locally produced transparencies.

LESSON PLAN FORMAT

INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL

Session title______________________________________Time for this session________

Time segment	Content	Materials needed
(Example)	(Example)	(Example)
8:30 - 8:40	Welcome/opening	Handouts: Binders, agenda, participants list, pre-course test
8:40 - 9:00	Introduction	
9:00 - 9:30	Pre-course Test	

Notes (things to say and do)

TIMETABLES

The following pages offer you a schedule-at-a-glance for this course. Separate timetables for Parts I, II, and III and a sample agenda for a three-day course are provided. As you can see, the course has three parts, and can be given in three full days. Parts I and II only require two days, and Parts I and III only require two days. Part I is devoted to basic concepts and contains preparatory material for each of the other two parts. Part II deals with interviewing skills, and Part III covers field investigation. It is important for you to know the job responsibilities of the health care providers who are to be trained in order to decide if a particular offering will be comprised of Parts I, II, and II; Parts I and II only; or Parts I and III only. Make sure to give the Pre- and Post-course Knowledge Assessments for the parts you actually cover in class.

If it is difficult to gather health care providers for three consecutive days, it is possible to cover the course in three days with each course day separated by one to three weeks. We recommend that you not shorten the course by deleting or abridging any of the content or by removing the practice interviews. The most powerful way for health care providers to brush up on their interviewing skills is to give them an opportunity to actually conduct interviews and receive helpful feedback.

If you modify the course by adding content to the material provided or by developing new sessions, we would appreciate hearing from you regarding your experiences. Include your comments on the report you send to us at the end of the course. Please share the material you add with us.

If you have questions or comments, please write or call your Program Consultant at:

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INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL

TIMETABLE

PART I: BASIC CONCEPTS	MINUTES
Introduction and Pre-course Knowledge Assessment	60
Principles of Communication	90
Assertiveness	45
Introduction to Interviewing	60
Problem Solving	45
Compliance	45
	345 = 5 hours, 45 minutes

INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL

TIMETABLE

PART II: INTERVIEWING	MINUTES
Planning and Structuring the Interview	75
Demonstration Interview	60
Practice Interviews	90
Interview Videotaping	120
Videotaped Interview Playback	145
	525 = 8 hours, 45 minutes

TIMETABLE

PART III: FIELD INVESTIGATION	MINUTES
Discussions	315 = 5 hours, 15 minutes

INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL

TIMETABLES

PARTS I, II, AND III

PART I: BASIC CONCEPTS	345 minutes	5 hours, 45 minutes
PART II: INTERVIEWING	525 minutes	8 hours, 45 minutes
PART III: FIELD INVESTIGATIONS	315 minutes	5 hours, 15 minutes
SELF-ASSESSMENT	60 minutes	1 hour, 00 minutes
POST-COURSE KNOWLEDGE ASSESSMENT	60 minutes	1 hour, 00 minutes
	1,305 minutes	21 hours, 45 minutes

PARTS I AND II

PART I: BASIC CONCEPTS	345 minutes	5 hours, 45 minutes
PART II: INTERVIEWING	525 minutes	8 hours, 45 minutes
SELF-ASSESSMENT	60 minutes	1 hour, 00 minutes
POST-COURSE KNOWLEDGE ASSESSMENT	60 minutes	1 hour, 00 minutes
	990 minutes	16 hours, 30 minutes

PARTS I AND III

PART I: BASIC CONCEPTS	345 minutes	5 hours, 45 minutes
PART III: FIELD INVESTIGATION	315 minutes	5 hours, 15 minutes
SELF-ASSESSMENT	60 minutes	1 hour, 00 minutes
POST-COURSE KNOWLEDGE ASSESSMENT	60 minutes	1 hour, 00 minutes
	780 minutes	13 hours, 00 minutes

INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL

SAMPLE AGENDA FOR PARTS I, II, and III

DAY 1

8:00 - 9:00	Introduction and Pre-course Knowledge Assessment
9:00 - 9:15	Break
9:15 - 10:45	Principles of Communication
10:45 - 11:30	Assertiveness
11:30 - 12:30	Lunch
12:30 - 1:30	Introduction to Interviewing
1:30 - 2:15	Problem Solving
2:15 - 2:30	Break
2:30 - 3:15	Compliance
3:15 - 4:30	Planning and Structuring the Interview

Day 2

8:00 - 9:00	Demonstration Interview
9:00 - 9:15	Break
9:15 - 10:45	Practice Interviews
10:45 - 11:45	Interview Videotaping
11:45 - 12:45	Lunch
12:45 - 1:45	Interview Videotaping
1:45 - 4:45	Videotaped Interview Playback

Day 3

8:00 - 10:00	Field Investigation Discussion
10:00 - 10:15	Break
10:15 - 12:00	Field Investigation Discussion
12:00 - 1:00	Lunch
1:00 - 2:30	Field Investigation Discussion
2:30 - 3:30	Self-assessment
3:30 - 4:30	Post-course Knowledge Assessment

Handouts

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HANDOUTS

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HANDOUTS

You will need to reproduce the following materials and have them available in the classroom for distribution. Your Instructor Guide tells you when to use the various handouts. A camera-ready copy of each, except the ones noted in parentheses, is included at this tab. Prepare your list of participants and course agenda in advance for reproduction.

(List of participants)

(Course agenda)

Objectives

Pre- and Post-course Knowledge Assessment

Assertive-Aggressive Role Play Exercise

Brief Tuberculosis Interview Outline

Compliance Case Study: Luther

Interview Case Study: Jake

Expanded Tuberculosis Interview Outline

Tuberculosis Interviewing Checklist

Demonstration Interview Case Study: Chandler

Self-assessment Form

Participant Rating Sheet

Participant Feedback Form

(Certificate)

INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL

OBJECTIVES

PARTS I AND II: INTERVIEWING AND INFLUENCING

FINAL OBJECTIVE

In a simulated interview situation, the participant will be able to apply the techniques presented in the course for interviewing a tuberculosis patient.

ENABLING OBJECTIVES

The participant will be able to:

1. Establish rapport with the patient and interact in a caring and professional manner.

2. Assess the patient's knowledge, attitudes, and concerns about tuberculosis by asking open-ended questions and using good listening techniques.

3. Describe basic transmission and pathogenesis concepts so that the patient's questions about the personal and public health implications of tuberculosis can be answered.

4. Negotiate an individualized plan for the patient to take medication, provide specific information about the medication, and establish a plan for followup clinic visits.

5. Explain the importance of and procedures used in contact identification and examination.

6. Obtain names and locating information of contacts.

7. Develop a plan for the referral for examination of each contact which utilizes the most effective method(s) of referral.

8. Identify, analyze, and resolve problems through the use of appropriate problem solving and motivational techniques.

9. Assess the validity and completeness of the information obtained from the patient interview.

INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL

OBJECTIVES

PARTS I AND III: INVESTIGATING AND INFLUENCING

FINAL OBJECTIVE

Given field investigation situations requiring client referrals, the participant will be able to interact with clients and successfully refer them for examination, treatment, and/or followup according to the guidelines presented in the course.

ENABLING OBJECTIVES

The participant will be able to:

1. Apply the relevant communication and problem solving techniques that are presented in the course.
2. Resolve field investigation problems, especially those related to locating clients, interacting with third parties, and maintaining confidentiality.
3. Describe the effective use of the telephone in investigations and referrals.
4. Develop a list of safety recommendations for the protection of health care providers in the field.

INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL

____PRE-COURSE KNOWLEDGE ASSESSMENT ____POST-COURSE KNOWLEDGE ASSESSMENT

PART I: BASIC CONCEPTS

1. Give two examples of nonverbal communication. The first is an example that contributes to positive, effective communication; the second is an example that is negative or contributes to ineffective communication.

   Example 1: (positive)

   Example 2: (negative)

2. Give an example of an open-ended question.

3. As a TB health care provider you have a great deal of influence over the outcome of your interaction with the client. Name two techniques you can use to communicate more effectively with your clients and coworkers.

4. When you work with patients, contacts, and other clients and with coworkers, you want to be persuasive, influential and effective. Look at this continuum:

   Passive Assertive Aggressive

   Place an "X" where you would like your communication style to be characterized. Define this style, and describe why you think it is most effective.

5. Briefly describe a situation where you could use confrontation as an effective strategy for problem solving with a recalcitrant client.

6. List three factors that influence patient compliance with tuberculosis treatment.

7. List three strategies that you can implement that would positively influence your client's compliance behavior.

PART II: INTERVIEWING

1. List three steps that you can take, or do take, to increase your effectiveness when interviewing patients.

2. Describe in a few sentences how you introduce the purpose of the initial interview with patients.

3. How would you, or do you, plan for resistance from the patient during an interview?

PART III: FIELD INVESTIGATION

1. A great deal of information is exchanged during field investigations. Name at least two major outcomes that you should achieve with a client during a field investigation.

2. Name two resources that you might use, or do use, to verify the address location of clients you need to contact in the field.

3. You have just arrived at the residence of a nonfamily contact of a newly diagnosed smear positive case of tuberculosis. Using the direct approach, you explain to the contact why you are there and what he/she should do. The contact then says to you "Do I have tuberculosis?" What do you say back to the contact?

4. The clinic supervisor gives you the name and address of a noncompliant patient and asks you to refer the patient to the clinic so that directly observed therapy can be started. When you arrive at the address, you find that the patient does not live there. What should you do?

ASSERTIVE-AGGRESSIVE ROLE PLAY

The Scenario

Client

You don't believe you have TB even though you have been coughing and losing weight for five weeks. You think the doctor at the clinic doesn't know what she's talking about, and you are not taking the medicine she prescribed. You have three small children living with you. They have had tuberculin skin tests which have not been read. You don't see the need to take them back to have the tests read, since you don't believe you have TB and they aren't sick.

Health care provider

You have been assigned to make a home visit to a bacteriologically confirmed pulmonary tuberculosis patient who is suspected of being noncompliant in taking prescribed medicine. The patient has not kept scheduled clinic appointments. Three small children live in the home with the patient. They have been given tuberculin skin tests, but were not returned to the clinic to have the tests read.

Your job is to assess the situation, find out if the patient is taking the prescribed drugs, and get the patient to bring the children back to the clinic for examination.

Observer

Your job is to watch the interaction. Observe the health care provider. Notice his/her verbal and nonverbal communication. Watch and listen to him/her interact aggressively or assertively with the client. Observe the client for reactions to the aggressive or assertive communication.

BRIEF TUBERCULOSIS INTERVIEW OUTLINE

I. Introduction

II. Body

- A. Patient Assessment
    1. Physical observation
    2. Patient concerns
    3. Personal information
    4. Medical history and disease comprehension
- B. Transmission Interruption Behaviors
    1. Take medication
    2. Cover cough
    3. Return for prescription refills, followup examinations, and medical evaluations
- C. Contact Investigation
    1. Introduction of the process
    2. Contact identification
        - a. Household environment contacts
        - b. Work/school environment contact
        - c. Leisure environment contacts
    3. Methods of referral

III. Conclusion

1. Questions and answers
2. Summary of main points

IV. Followup

1. Plan for next interaction

DHHS:PHS:CDC:CPS:DTBC:9/87

COMPLIANCE CASE STUDY

LUTHER

Luther is a 54 year-old single unemployed male. He is a veteran, receives a small disability pension, and sometimes picks up odd jobs in the warehouses and diners on River Front Street. He lives in a single room occupancy hotel.

Sixteen weeks ago he was brought by the police to the emergency room of City General Hospital for treatment of stab wounds to the right arm and cuts on the neck and face resulting from a fight outside a tavern on the waterfront. He was admitted for treatment and observation. Upon admission he was intoxicated, appeared poorly nourished and under weight, and had a productive cough. The chest radiograph revealed an infiltrate in the left upper lobe. Sputum smears were positive for AFB. He was started on isoniazid (INH) 300 mg., rifampin (RIF) 600 mg., and pyrazinamide (PZA) 2 g. daily. He remained hospitalized for five days. On the day of discharge, the infection control nurse telephoned a report to the health department and instructed him to go to the tuberculosis clinic at the health department the next morning for evaluation and a supply of medicine. He failed to keep the appointment. The next week an outreach worker was assigned to locate Luther and persuade him to come to the clinic. After considerable time and effort, the outreach worker found him lying on a park bench near the hotel where he lives. Luther agreed to ride to the clinic, a distance of 6 miles from his hotel, with the outreach worker.

The clinician had left orders for the staff to administer a tuberculin skin test, obtain a chest x-ray, collect sputum specimens, and issue a 30-day supply of drugs. An hour and a half later, these services were performed, and a clinic nurse did a five-minute interview which resulted in her obtaining the names of two contacts. He was instructed to report back to the clinic at 8:00 a.m. in two days to have the skin test read and to return in 30 days for more drugs. The outreach worker had left the clinic to work in the field and was not expected back until the next morning. Luther walked to his hotel. The nurse noted in the record that the patient did not seem to be concerned about having tuberculosis and that he had been warned not to drink while he was taking tuberculosis drugs.

Luther failed to return to have his skin test read. The outreach worker brought him to the clinic the next day, and the skin test was read as positive at 15 mm. The nurse told him the test was positive, to continue the medicine, and to come back as previously instructed for his next supply of drugs.

The State laboratory report indicated that the sputum culture was positive for M. tuberculosis.

Luther did not return to the clinic to pick up his second month's supply of drugs. Seven days later, the outreach worker was asked to give him another appointment. An appointment card was left under Luther's door, but he did not come in on the scheduled day. A week later, Luther came to the clinic at 4:30 p.m. asking to see a doctor. He was told the doctor was not in, but was given his drugs. He did not return as instructed to pick up his third month's supply of medicine.

DHHS:PHS:CDC:CPS:DTBC:9/87

INTERVIEW CASE STUDY

JAKE

Jake Buckner is a 37 year old male who is the office manager at Minico, Inc. Four weeks ago, he visited the company nurse complaining of fever, loss of appetite, and a cough of 2 weeks duration. The nurse suggested that he make an appointment to see his private physician. One week later, Jake was evaluated by his physician who diagnosed him with acute bronchial infection and prescribed an antibiotic and decongestant cough formula. He continued to work although his symptoms persisted, but he took 2 days of sick leave and left work early twice because of fatigue. Last Monday Jake returned to his physician. He was still coughing and had lost a total of 9 pounds. The physician referred him to a radiologist for a chest x-ray examination. The chest x-ray, which was read on the same day, showed a subapical infiltrate in the left lung. Jake's physician called the city health department and made arrangements for him to be seen on Tuesday for an evaluation. At the health department, Jake was given a Mantoux tuberculin skin test and sputum specimens were obtained. The clinician, after reviewing Jake's history, clinical findings, and chest x-ray, prescribed isoniazid (INH) 300 mg., rifampin (RIF) 600 mg., and pyrazinamide (PZA) 2 g. daily. He instructed Jake to return to the clinic on Thursday to have his skin test read and to get his laboratory report.

Thursday: Jake returned to the clinic. The nurse read his tuberculin skin test as 15 millimeters of induration. The laboratory report indicated numerous acid-fast bacilli seen on smear, culture pending. The clinician made a presumptive diagnosis of pulmonary tuberculosis and instructed Jake to continue the medicines that were prescribed the day before yesterday. The clinician sent Jake with his record to your office for an interview.

EXPANDED TUBERCULOSIS INTERVIEW OUTLINE

I. Introduction

A. Introduce yourself to the patient. Begin building rapport.

B. Explain your role in the tuberculosis control program.

C. Focus the patient's attention on tuberculosis. One way to do this is by saying:

"Dr. ___________ tells me that you have tuberculosis" or "I see in your medical record that Dr. __________has diagnosed you as having tuberculosis. The doctor has asked me to talk with you, as I do with all tuberculosis patients."

D. Explain the purpose of the interview:

1. To help the patient actively participate in the treatment and management of the disease so that good health is restored.

2. To identify others with infection and disease to stop the spread of tuberculosis.

Make a transition from the Introduction to the Body with a "bridge" statement/question. Examples to choose from are:

"I realize that you may already know a great deal about tuberculosis; however, today I want to go over the most important points again about this disease."

"Tell me what you have heard or read about tuberculosis. There is a lot of information about this disease that you have heard that may not really apply to your case."

"I know that you have received a lot of information about tuberculosis. What questions do you have"?

"Tell me what is the most confusing (hard, difficult to understand, hard to do, hard to remember, etc.) for you about tuberculosis."

"What will be the hardest thing for you to do that the doctor has recommended?"

"Some people find that tuberculosis is hard to deal with. What types of trouble do you expect you'll have with this disease?"

"What would help you take your tuberculosis medicine on a regular basis?"

"Why do you think some people have trouble taking their tuberculosis medicine? What would influence you the most to take your medicine?"

II. Body

A. Patient Assessment

Continue building rapport and begin problem solving.

1. Physical observation

   a. Make note of any physical signs, such as alcoholism, drug abuse, nutritional status, lifestyle, and other illnesses, that may be indicative of the patient's cooperation in the interview and have a negative effect on compliance.

   b. Observe the patient's body language throughout the interview.

2. Patient concerns

   a. Identify any patient concerns (treatment, cure, clinic appointments, protection of family members, clinic experience, etc.) Resolve those concerns now even if it means departing from the planned format of the interview.

   b. Assess the patient's intellectual level, attitudes, and needs. Begin planning what and how to tell the patient about tuberculosis, treatment, contact investigation, etc.

   c. Assess the patient's communication skills. Begin to anticipate problems. Develop potential strategies for subsequent sections of the interview.

10

3. Personal information

Explain why it is important for you to have accurate personal as well as medical information in order to help.

Determine the extent of rapport developed in the interview to this point. Observe the patient and assess responses.

a. What is your full name?

b. What other name(s) do you go by? (What do your friends call you? What is your nickname?)

c. May I call you ____________?

d. How old are you? (What is your age? What is your birthday?)

e. What is your marital status? (Married, single, widowed, or divorced?)

f. Where do you live now? (Verify with drivers license, ID card, etc.)

g. How long have you lived at _______________?

h. How do you (I) get to your house/apartment? (What are the directions to your house/apartment?)

i. Where did you live before you moved to the house/apartment you live in now?

j. What is your telephone number? (Privately verify with the telephone directory before the patient leaves.)

k. Whom may I contact if I (we) need to reach you when you are not at home? (Name, address, telephone number.)

l. Who is your next of kin? (Name, relationship, address, telephone number.)

m. Where do you work (go to school)?

n. What hours do you work (go to school)?

4. Medical history and disease comprehension

a. What do you know about tuberculosis? (Do not ask this question, if you asked it in the "bridge."

Reinforce what the patient knows about the disease and correct any misconceptions.

Explain the natural course of the disease and mode of transmission using language the patient can understand. Focus on the shared air principle. Avoid giving a medical lecture.

b. When were you last examined (tested) for tuberculosis infection and disease?

c. What were the examination results?

d. When did you start coughing?

e. How frequently (how much) do you cough?

f. How much sputum do you bring up when you cough?

e. When did you first notice being hoarse or having laryngitis?

f. When did your chills and fever begin?

g. How much weight have you lost?

h. When did you notice you were losing weight?

i. Who has (or has had) tuberculosis that you think you might have been exposed to?

Discuss the patient's diagnosis and treatment recommendations (current status):

1. Tuberculin test results
2. X-ray/clinical findings
3. Smear and culture results
5. Site of disease
5. Chemotherapy recommendations

B. Transmission Interruption Behaviors

1. Take medication

   a. Explain that the drugs kill tubercle bacilli. Reinforce the personal and public health benefits of taking the medicine.

   b. Identify and explain each prescribed drug. Show the bottles to the patient. Go over the written instructions on the labels.

   c. Discuss the dosage of each drug.

   d. Establish a specific schedule for the patient to take the drugs.

   e. Discuss potential side effects.

   f. Emphasize the need to take the drugs at the times and for the length of time prescribed.

   g. Identify and discuss potential compliance problems. Incorporate strategies to enhance compliance.

2. Cover cough

   a. Instruct the patient about using a tissue to cover mouth and nose when coughing. Explain proper disposal technique. Emphasize that taking the drugs as prescribed and covering the cough are the most important measures the patient can take to protect others.

   b. Discuss venting the room air to the outside as another technique for protecting others.

3. Return for prescription refills, followup examinations, and medical evaluations

   a. Explain why the drugs are issued in 30-day supplies. Re-emphasize the importance of continuity of therapy.

   b. Explain the need for sputum and chest x-ray examinations. Discuss the approximate schedule. Show containers to the patient. Instruct the patient on collecting and submitting sputum specimens to the laboratory. Provide containers.

   c. Discuss schedule of physician and/or nurse monitoring of the patient's progress during therapy.

   d. Establish (negotiate) date and time for the next clinic visit.

   e. Identify and discuss potential compliance problems.

C. Contact Investigation

1. Introduction of the process

a. Review the patient's comprehension of the disease and the mode of transmission. Focus on the shared air principle.

b. Discuss the importance of examinations for persons who have shared air with the patient and explain the type of examination(s) they will receive.

c. Assess the patient's response to the interview thus far and determine if he/she has concerns about contact investigation activities.

2. Contact identification

a. Household environment contacts

1. How is your house/apartment heated in the cold weather months?
2. How do you cool your house/apartment in the hot weather months?
3. How many people live with you now in your house/apartment?
4. How many other people have lived with you in your house/apartment during the past six months?
5. During the past three months, how many overnight guests have you had at your house/apartment?
6. How many daytime or evening visitors, e.g., neighbors, friends, and relatives, have been to your house/apartment in the past two or three months?
7. When was the last time you were out of town?
8. On the nights when you don't go to your house/apartment to sleep, where do you spend the night?
9. How many bedrooms are in your house/apartment?
10. How many other people sleep in the same room you sleep in?

For homeless and transient patients, modify the above questions to obtain information about shelters, missions, jails, migrant camps, etc.

Use open-ended questions and ask the patient for the following information about each person now living in the household:

Name and nickname

Relationship to patient

Age

Sex

Physical description

Employer or school

Other locating information.

Use open-ended questions and ask the patient for the following information about other people who have lived in the household during the recent past, overnight guests, and daytime visitors:

Name and nickname

Address

Directions to residence

Telephone number (verify with telephone directory)

Who the person lives with

Relationship to patient (relative, friend, neighbor, etc.)

Age

Sex

Physical description

Employer or school

Other identifying and locating information

Analyze all the responses for conflicts in information. Identify problems and confront inconsistencies. Evaluate problems and select appropriate solutions along the way.

b. Work/school environment contacts

1. How long have you worked (gone to school) at______________________?
2. What kind of work do you do (What grade are you in) at ______________________?
3. Where do you do your work? Inside or outside?
4. (If inside) What kind of space do you work in? Enclosed or open? (Ask the patient to describe the area.)
5. How many people work in the same work space with you?
6. In addition to the employees in your work space, how many other employees do you spend time with at work?
7. What type of heating and cooling systems does your place of employment (school) have?
8. What kind of lunch and break areas does your place of employment (school) have?
9. Where do you eat lunch?
10. How (transportation method) do you get to and from work (school)?

For unemployed (not in school) patients, modify the questions to obtain information about the places (other than the house/apartment) where the patient spends time.

If the patient works in a closed indoor setting, or if the probability exists that any coworkers have been exposed, use open-ended questions and ask the patient for the following information about work associates (classmates, teachers):

Name and nickname

Address

Directions to residence

Telephone number (verify with telephone directory)

Who the person lives with

Age

Race

Sex

Physical description

Other identifying and locating information

Analyze all the responses for conflicts in information. Identify problems and confront inconsistencies. Evaluate problems and select appropriate solutions along the way.

c. Leisure Environment Contacts

1. How do you spend your spare (leisure) time?

2. Which clubs, bars, and meeting places do you go to most frequently?

3. How much time do you spend there?

4. How many people do you regularly see when you are at your club (bar, meeting place)?

5. What church do you attend?

6. Do you sing in the church choir or other musical group?

f. How many "best friends" do you have?

g. How many steady sex partners do you have?

h. Which places have you traveled to during the past two or three months?

i. When was the last time you were out of town overnight?

j. How long were you away on these trips?

k. Where did you stay?

If information about leisure activities suggests that exposure of others is a probability, use open-ended questions and ask the patient for the following information about persons with whom he/she shares leisure time:

Name and nickname

Address

Directions to address

Telephone number (verify with telephone directory)

Who the person lives with

Age

Race

Sex

Physical description

Other identifying and locating information

Sex partners including extramarital partners

Analyze all the responses for conflicts in information. Identify problems and confront inconsistencies. Evaluate problems and select appropriate solutions along the way.

NOTE: Your sensitivity to the patient's answers to the preceding questions is extremely important. Most patients will respond positively and openly; however, be prepared to begin problem solving and provide a reassuring answer if the patient asks, "Why do you need that information?" This type of response, along with nonverbal signs of discomfort, are indicators of patient concerns. Assess the degree of rapport that has been established and address any previously unexpressed patient concerns; resolve problems. Restate the purpose of the interview. Continue problem solving to deal with concerns which are commanding the patient's attention before proceeding from one segment of the interview to the next.

3. Methods of referral

a. Inform the patient that contact investigation and referrals will be carried out immediately.

b. Determine the patient's capability to participate in contact referrals.

c. Inform the patient that it is sometimes necessary for site visits to be made to the home, workplace, school, leisure establishments, etc. to assess the shared air environment in order to accurately structure the contact investigation and referral process. Stress again the importance of an examination for each contact.

d. There are two basic contact referral options:

   1. Health department referral: You (or other health care provider) assume full responsibility for informing the contact about exposure and the need for examination, and you make the referral.

   2. Patient referral: The patient agrees to inform the contact about the need for examination and to make the initial referral attempt.

e. Discuss the referral options with the patient. Ask for decisions about each person who is considered most likely to be a contact. For those the patient plans to refer, establish an understanding which defines:

   Patient's role

   Your role

   How/when the referral will be made

   Where the contact will be referred

III. Conclusion

A. Ask for and answer any questions the patient may have.

B. Evaluate remaining patient needs or potential compliance problems.

C. Review and reinforce all components of the compliance plan. Explain handouts that are given to the patient.

D. Restate the date of the next clinic visit.

E. Make arrangements for a re-interview and home visit.

F. Reinforce the procedures for referral of each contact.

G. Analyze case/contact information for inconsistencies or missing information.

H. Confront inconsistencies and apply problem solving strategies.

I. Express appreciation to the patient and close the interview.

IV. Followup

Immediately develop plans for your next interaction with the patient.

TUBERCULOSIS INTERVIEWING
CHECKLIST

I. INTRODUCTION	YES	NO
1. Did the Interviewer establish rapport with the patient?		
2. Did the Interviewer define the purpose of the interview for the patient?		
II. BODY		
1. Did the Interviewer identify patient concerns?		
2. Did the Interviewer resolve patient concerns?		
3. Did the Interviewer adequately inform the patient about his/her diagnosis/treatment?		
4. Did the Interviewer obtain sufficient information to structure contact investigation activities?		
III. CONCLUSION		
1. Were the main points summarized?		
2. Were all of the patient's questions answered?		
3. Was a date and time established for the next interview?		
IV. FOLLOW-UP		
1. Did the Interviewer have a follow-up strategy?		

INTERVIEWER'S STRENGTHS:

INTERVIEWER'S WEAKNESSES:

COMMENTS:

DHHS:PHS:CDC:CPS:DTBC:9/87

DEMONSTRATION INTERVIEW CASE STUDY

NAME: Chandler, Matilda (F) or Leonard (M)
ADDRESS: Rt. # 2, Old Marshall Highway
________________________, _______
AGE: 35
DATE OF BIRTH: 6/13/__
MARITAL STATUS: Married. Three children.
OCCUPATION: Ward clerk (Matilda); maintenance carpenter (Leonard)
PLACE OF EMPLOYMENT: Palmer Ford Nursing Home

On Thursday of last week, the patient was evaluated by his/her private physician, Dr. Kenneth Rice. He/She gave a history of a cough of two weeks duration, loss of appetite, and sleeplessness. On the day prior to evaluation, he/she reported having coughed up blood in the early morning. Dr. Rice collected sputum specimens and sent them to the State laboratory. He called the health department and made arrangements for the patient to have a tuberculin skin test, chest x-ray examination, and clinical evaluation on Friday. At the health department tuberculosis clinic, a tuberculin skin test (0.01 ml PPD-T, 5 TU, intradermal) was administered, PA chest films were made, and sputum specimens were collected and forwarded to the State laboratory for smear and culture examination. The patient gave a history of a negative (nonsignificant) tuberculin skin test a year and a half ago when first employed at Palmer Ford Nursing Home. The patient stated that his/her paternal grandmother and a paternal great uncle had been patients at the Claxton Sanatorium about 30 years ago. The grandmother died there. The clinic nurse called Dr. Holland at her private group practice office and gave her the patient's history. The chest x-ray appeared to be abnormal and the nurse reported this to Dr. Holland. Dr. Holland gave verbal orders to start therapy with INH 300 mg., RIF 600 mg., and PZA 2 g. daily. The patient was instructed to report back to the clinic on Monday of the following week to have his/her tuberculin skin test read and to have a clinical evaluation by Dr. Holland.

The patient returned to clinic today (Monday). His/Her skin test reaction is recorded as significant at 18 mm. of induration. The chest x-ray reveals an infiltrate in the right upper lobe with cavitation. The laboratory report (on specimens submitted by Dr. Rice) indicates numerous AFB seen on smear, culture pending.

Diagnosis: Pulmonary Tuberculosis (suspect, pending culture results).

Recommendations: Continue INH, RIF, and PZA daily as prescribed. Interview patient. Make home visit. Patient not to return to work. Decision about returning to work contingent upon results of next evaluation. Return in 30 days.

INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL

SELF-ASSESSMENT

I. Skill Rating

For each skill listed below, rate yourself (one number between 1 and 10) and list the actions you plan to take to improve or sustain that skill.

Skill	Rating - + 1---- 10	Action steps for future skill enhancement
1. Nonverbal communication		
2. Listening		
3. Obtaining complete, accurate information from clients		
4. Giving information that persuades clients to take positive TB control action		
5. Self-confidence		
6. Confronting clients' problems		
7. Relating to third parties in the field		

Skill	Rating - + 1---- 10	Action steps for future skill enhancement
8. Using field resource persons		
9. Finding people with questionable addresses		
10. Handling clinic referral slips and notes		
11. Documenting your investigations and referrals		

II. Role Analysis

Review the interviewing, investigating, and compliance influencing activities that you are responsible for at work. List those and other functions here.

______________________________ __________

______________________________ __________

______________________________ __________

______________________________ __________

Other ______________________________ __________

______________________________ __________

____

100%

Now think about the amount of time you spend on each. Write in the percentage of time you spend on each function. The total should add up to 100%.

Do these percentages reflect the investment you should be making?

Now list the percentages again.

Record the way (expressed as a percentage) you think your time should be distributed under optimum conditions.

Functions	% Now	% Optimum
Other		
	100%	100%

Describe your strategy for changing the situation as it is now so that it comes closer to the optimum.

Action Steps:

III. In one brief paragraph or list, describe how you plan to conduct interviewing, investigating, and compliance influencing activities differently now that you have had the opportunity to look at these critical aspects of your job.

What resources, support, permissions, etc. will you need to make these changes?

IV. Use a clean sheet of paper and write a "Dear Boss" letter. Thank your boss for sending you to this course. Include in your letter a brief report based on your action plan; discuss what you intend to do or change as a result of this training.

Division of Tuberculosis Control
Center for Prevention Services
Centers for Disease Control

INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL

PARTICIPANT'S COURSE KNOWLEDGE ASSESSMENT RATING SHEET

Participant's Name: ______________________________

Participant's SS#: ______________________________

Dates of Course: ______________________________

Location of Course: ______________________________

Instructor(s) ______________________________

____

Check the parts of this course that you completed:

Part I Basic Concepts ______

Part II Interviewing ______

Part III Field Investigation ______

Pre-course Knowledge Assessment Score (# correct): ________

Post-course Knowledge Assessment Score: ________

DHHS:PHS:CDC:CPS:DTBC:9/87

Division of Tuberculosis Control
Center for Prevention Services
Centers for Disease Control

INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL

PARTICIPANT'S COURSE FEEDBACK FORM

Instructor(s)________________________ Dates________ Location____________________

A. SUBJECT CONTENT	TOO MUCH	BALANCED	NOT ENOUGH
1. Theoretical	☐	☐	☐
2. Practical	☐	☐	☐

B. SUBJECT LEVEL	TOO ELEMENTARY	JUST RIGHT	TOO ADVANCED
	☐	☐	☐

C. PRESENTATIONS	EFFECTIVE	SOMEWHAT EFFECTIVE	NOT EFFECTIVE
1. Ability to Communicate	☐	☐	☐
2. Emphasis of Key Points	☐	☐	☐
3. Visual Aids	☐	☐	☐
4. Handout Material	☐	☐	☐
5. Role Plays/Discussions	☐	☐	☐

D. PLEASE RECORD YOUR OVERALL REACTIONS TO THE INSTRUCTOR(S) BY PLACING AN "X" IN IN THE APPROPRIATE BOX ON THE SCALE.

Excellent					Good					Fair					Poor				
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20	19	18	17	16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1

E. YOUR SUGGESTIONS FOR IMPROVING THIS COURSE WOULD BE APPRECIATED

____
____
____

F. OTHER COMMENTS

____
____
____

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Part I: Basic Concepts

PART I: BASIC CONCEPTS

OVERVIEW OF PART I: BASIC CONCEPTS

"Part I, Basic Concepts" is the foundation for INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL. It gives participants an opportunity to practice communication skills that are the basis for good interviewing, investigating, and influencing techniques. Through practice and feedback, participants will focus on verbal and nonverbal communication skills, listening skills, open-ended questions, assertiveness skills, compliance influencing strategies, and problem solving techniques. Much of the skill development will occur during the role playing exercises. Time should be dedicated in each session to discussion and relating the course content to the day-to-day problems and issues that TB health care providers face.

Introduction

PART I: BASIC CONCEPTS

INTRODUCTION

INTRODUCTION AND PRE-COURSE KNOWLEDGE ASSESSMENT

TIME: 60 MINUTES

MATERIALS/EQUIPMENT

Flip chart and marking pens

Binders for Participant Guides, note paper (punched for binders), pencils/pens

Name tags

Cards for name tents

Handouts: List of participants
Agenda
Objectives
Pre-course Knowledge Assessment

PREPARATION

- Set up the tables and chairs, supplies, and equipment.
- Put a binder, note paper, pencil or pen, name tag, and name tent at each participant's place around the table. (Note: These may be given to participants at registration.)
- Write your name and the names of other instructors, office(s), and telephone number(s) on the chalk board or flip chart.
- Write the name of the course on the board or flip chart.
- Locate the break and restroom areas.
- Prepare a list of local restaurants.

REQUIRED READING FOR PARTICIPANTS

None for this session, although participants should be expected to have reviewed the entire Participant Guide before arriving.

INSTRUCTOR NOTES	LESSON PLAN
WELCOME Time:______________	
	Welcome to INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL. This course was developed by the Division of Tuberculosis Control, Centers for Disease Control (CDC) in Atlanta, Georgia, and has been made available to State and city health departments for use in training tuberculosis control staff. Unlike the TB TODAY! course which is usually taught in Atlanta by CDC staff and consultants, this course is designed to be taught in the field by State and local health department personnel. INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL is an approved CDC course which we have chosen to use in our program of staff training.
	My name is______________________________. I am the ______________________________.
Briefly describe your role and responsibilities in the health department's tuberculosis control program or other organizational component.	
Introduce the other instructor(s) in the same manner.	
	I (we) will be the instructor(s).
Indicate the telephone number(s) which may be used to receive messages during the course.	

INSTRUCTOR NOTES	LESSON PLAN
Introduce any guests who are present.	
NOTE: Guests need to be treated like participants during the portions of the course when they are present. Passive observers may have a negative effect on the atmosphere of the class. Guests should sit with participants and need to be involved during the course.	
HANDOUT List of participants	In almost all training courses, especially ones that have a small enrollment like this class, participants introduce themselves at about this point in the proceedings. We're going to do it differently. Your introductions will be done a little later. There's a reason for this which you will discover. For now, though, I am going to give you a list of class participants, and ask that you fill out and wear your name tag and place your name tent on the table in front of you.
INTRODUCTION Time: ____________	
Present a brief overview of the course and its purpose.	The purpose of this course is to enable participants to learn and/or sharpen skills that are necessary for effectively interviewing tuberculosis patients and suspects, conducting field investigations, and influencing compliance with treatment recommendations. The course description that we sent you tells us that we are going to be reviewing principles of communication and learning how to be persuasive, how to engender trust, how to collect complete information, how to approach and work through problems, and how to encourage clients to be

INSTRUCTOR NOTES | **LESSON PLAN**

actively involved in treatment. You will get the most out of this course if you will do your preparatory reading and other homework, become an active member of the class, and seek ways to put the concepts taught in class into practice.

Instruction methods include lectures, group discussions, role playing exercises, case studies, practice interviews, and videotaping and playback.

The Participant Guide is your primary text. It contains the reading material for each session. Be certain you have done the required reading for each session prior to coming to class. You may wish to take notes in some sessions. Note paper has been included in your Guide.

There will be two tests: a Pre-course Knowledge Assessment and a Post-course Knowledge Assessment. These tests will enable you to measure the increased knowledge that you gain as a result of this course.

HANDOUT

Agenda

Let's take a look at the agenda now to see what's in store for us.

Please note that class begins at __________ o'clock and ends at __________ o'clock.

Review the daily schedules and discuss the following as appropriate:

Breaks and restroom locations.

Lunch breaks and nearby restaurants.

Dinner and/or social hour arrangements.

Lodging arrangements.

INSTRUCTOR NOTES	LESSON PLAN
No smoking and other house rules. Travel arrangements at the end of the course.	
	The course is in three parts. "Part I, Basic Concepts" is the foundation. It gives you an opportunity to practice communication skills that are essential to good interviewing, investigating, and influencing techniques. Part I contains preparatory material which is essential for both of the other parts. "Part II, Interviewing" deals with the skills of interviewing patients and suspects. "Part III, Field Investigation" focuses on outreach activities in the community.
HANDOUT Objectives	
	I want to briefly go over the course objectives with you. Notice that there are objectives for Parts I and II which relate to interviewing and influencing and other objectives for Part I and III relating to investigating and influencing. The objectives are behavioral, i.e., they define what you will be able to do as a result of the training you receive in this course. The objectives are based on course content and represent my (our) expectations for you. In addition to these objectives, each session has one or more specific objectives to guide you. These are included with the reading material in your *Guide*. You should become familiar with these "learning" objectives as you prepare for classroom sessions.
Call for questions. Move quickly through this segment so as not to get into a discussion of content which is premature.	

INSTRUCTOR NOTES | **LESSON PLAN**

Are there any questions or comments on the Guide, agenda, and objectives?

I want to remind you that the course will keep you busy. What you learn really depends on you - how well you prepare for class and how much you participate in each session. We do expect you to complete the reading assignments before coming to class. I encourage each of you to actively join in the group discussions and other classroom activities and to ask questions.

Relax, but remain alert, and have fun.

Please tell me if you have special needs. I'll be happy to help anyone who needs special assistance.

PRE-COURSE TEST
Time: ________

HANDOUT

Pre-course Knowledge Assessment

Prepare the class for the test.

It is time now for the Pre-course Knowledge Assessment.

Each of you has had prior instruction and experience in tuberculosis control before attending this course. Participants in INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL are required to have an understanding of tuberculosis control as a prerequisite for this course. The "basics" will not be covered in this course, and related questions are not included in the Pre- and Post-course Knowledge Assessments. However, we want you to apply your knowledge of tuberculosis and tuberculosis control in this course while you are learning and sharpening interviewing, investigating, and influencing skills.

INSTRUCTOR NOTES	**LESSON PLAN**
	The purposes of the Pre-course Knowledge Assessment are: 1. To indicate to me and to you the level of knowledge you have now about interviewing, investigating, and influencing so that instruction may be targeted to meet your specific training needs; and 2. To enable me and you to measure the extent to which your knowledge increases as a result of the course. The Pre- and Post-course Knowledge Assessments will be returned to you.
Distribute the forms and allow each person to complete the test at his/her own rate within reason. Announce that a BREAK will follow, and that when they finish the test and return it to you, they may leave the room.	
You may choose to have participants correct their own in class and turn them back to you. They can be returned to participants after the post-course test is administered.	
	The next session will begin promptly at ___________ o'clock.

INTRODUCTION

HANDOUTS

List of participants

Agenda

Objectives

Pre-course Knowledge Assessment

INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL

OBJECTIVES

PARTS I AND II: INTERVIEWING AND INFLUENCING

FINAL OBJECTIVE

In a simulated interview situation, the participant will be able to apply the techniques presented in the course for interviewing a tuberculosis patient.

ENABLING OBJECTIVES

The participant will be able to:

1. Establish rapport with the patient and interact in a caring and professional manner.
2. Assess the patient's knowledge, attitudes, and concerns about tuberculosis by asking open-ended questions and using good listening techniques.
3. Describe basic transmission and pathogenesis concepts so that the patient's questions about the personal and public health implications of tuberculosis can be answered.
4. Negotiate an individualized plan for the patient to take medication, provide specific information about the medication, and establish a plan for followup clinic visits.
5. Explain the importance of and procedures used in contact identification and examination.
6. Obtain names and locating information of contacts.
7. Develop a plan for the referral for examination of each contact which utilizes the most effective method(s) of referral.
8. Identify, analyze, and resolve problems through the use of appropriate problem solving and motivational techniques.
9. Assess the validity and completeness of the information obtained from the patient interview.

INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL

OBJECTIVES

PARTS I AND III: INVESTIGATING AND INFLUENCING

FINAL OBJECTIVE

Given field investigation situations requiring client referrals, the participant will be able to interact with clients and successfully refer them for examination, treatment, and/or followup according to the guidelines presented in the course.

ENABLING OBJECTIVES

The participant will be able to:

1. Apply the relevant communication and problem solving techniques that are presented in the course.
2. Resolve field investigation problems, especially those related to locating clients, interacting with third parties, and maintaining confidentiality.
3. Describe the effective use of the telephone in investigations and referrals.
4. Develop a list of safety recommendations for the protection of health care providers in the field.

INTERVIEWING, INVESTIGATING, AND INFLUENCING:
APPLICATIONS TO TUBERCULOSIS CONTROL

____PRE-COURSE KNOWLEDGE ASSESSMENT ____POST-COURSE KNOWLEDGE ASSESSMENT

PART I: BASIC CONCEPTS

1. Give two examples of nonverbal communication. The first is an example that contributes to positive, effective communication; the second is an example that is negative or contributes to ineffective communication.

   Example 1: (positive)

   Example 2: (negative)

2. Give an example of an open-ended question.

3. As a TB health care provider you have a great deal of influence over the outcome of your interaction with the client. Name two techniques you can use to communicate more effectively with your clients and coworkers.

4. When you work with patients, contacts, and other clients and with coworkers, you want to be persuasive, influential and effective. Look at this continuum:

   Passive Assertive Aggressive

   Place an "X" where you would like your communication style to be characterized. Define this style, and describe why you think it is most effective.

5. Briefly describe a situation where you could use confrontation as an effective strategy for problem solving with a recalcitrant client.

6. List three factors that influence patient compliance with tuberculosis treatment.

7. List three strategies that you can implement that would positively influence your client's compliance behavior.

PART II: INTERVIEWING

1. List three steps that you can take, or do take, to increase your *effectiveness* when interviewing patients.

2. Describe in a few sentences how you introduce the purpose of the initial interview with patients.

3. How would you, or do you, plan for resistance from the patient during an interview?

PART III: FIELD INVESTIGATION

1. A great deal of information is exchanged during field investigations. Name at least two major outcomes that you should achieve with a client during a field investigation.

2. Name two resources that you might use, or do use, to verify the address location of clients you need to contact in the field.

3. You have just arrived at the residence of a nonfamily contact of a newly diagnosed smear positive case of tuberculosis. Using the direct approach, you explain to the contact why you are there and what he/she should do. The contact then says to you "Do I have tuberculosis?" What do you say back to the contact?

4. The clinic supervisor gives you the name and address of a noncompliant patient and asks you to refer the patient to the clinic so that directly observed therapy can be started. When you arrive at the address, you find that the patient does not live there. What should you do?

Communication

PART I: BASIC CONCEPTS

PRINCIPLES OF COMMUNICATION

PRINCIPLES OF COMMUNICATION

TIME: 90 MINUTES

MATERIALS/EQUIPMENT

Flip chart

NOTE

This session can be modified, if necessary, to meet special needs. For example, if the participants work with foreign-born clients, you may want to include materials, examples, and ideas that are culturally and ethnically sensitive to the group being served.

RESOURCES

There are many commercially available resources to help you develop and teach this session. In addition to using the material provided, you should feel free to further develop the session using the resources noted below or others.

Kinlaw DC. Listening and communicating skills. University Associates, Inc. Includes 39 structured activities with observation forms, worksheets and a 30-minute tape. $53.50. 619-578-5900.

Morris KT, Cinnamon, KM. A handbook of verbal group exercises. A handbook of nonverbal group exercises. University Associates, Inc. The set $29.95.

Waitley DE. The inner winner. Series of 12 audiocassettes. The Human Resources Co. 7300 N. Lehigh Ave. Chicago, IL 60648. The set $40.00. 800-621-5199 or 312-647-0300.

SUGGESTED READING FOR PARTICIPANTS

Hanks K. How to motivate others to do what you want and thank you for the opportunity. Argus Communications, 1982.

Nirenberg J. How to sell your ideas. McGraw-Hill, 1984.

REQUIRED READING FOR PARTICIPANTS

Participant Guide material for this session.

OBJECTIVE

Participants will be able to put effective communication techniques, particularly those designed to improve patient compliance with desired behaviors, into practice.

INSTRUCTOR NOTES	LESSON PLAN
INTRODUCTION Time: ______________	The title of this session is "Principles of Communication." For the next hour and a half we are going to be discussing communication. Communication is basic to all we do in tuberculosis control. The ways we communicate with clients determine whether our interactions with them are positive or negative, so it is appropriate for us to begin our course on interviewing, investigating, and influencing with a look at communication.
FLIP CHART List in advance the books, articles, courses you reccommend to participants.	The instruction on communication in this course is abbreviated and is only one of many ways to approach the subject. There is a vast amount of material available on the topic, and I encourage you to read articles and books or take other courses to expand your knowledge and skills. Two suggested books to read are mentioned in your Guide. I have listed some other references on the flip chart for your consideration. Our study of communication is basic, but focuses on the principles we can employ to improve our communication with clients. What does the word "communication" mean to you? Let's hear some of your definitions.

INSTRUCTOR NOTES	LESSON PLAN
FLIP CHART Following a discussion, write this definition on the flip chart, if it hasn't already in essence been covered.	The exchange of information by words, symbols, or actions.
	The *Participant Guide* states communication is a process whereby we share something of ourselves with others. What are some of the things we share with others through communication?
FLIP CHART Write down all responses. These are the ones you are looking for.	Ideas Opinions Values Goals Feelings
CALL ON PARTICIPANTS Ask them to give examples. Use the ones provided if they have trouble coming up with their own.	______________, give us an example of how you would communicate an idea. Make a statement to us that communicates an idea. Example: "Let's try giving our noncompliant patients incentives to take their medicine."

INSTRUCTOR NOTES	LESSON PLAN

Let's hear a sentence that communicates an opinion.

Example: "Our tuberculosis control program is tops in the State."

What about values? Give us a sentence that communicates a value.

Example: "I really like my job in the tuberculosis control program."

Someone communicate a goal.

Example: "By the end of June, all my patients will be taking their drugs as prescribed."

How about a feeling?

Example: "Jake will come to the clinic tomorrow, I just know he will."

When we talk with others and they talk with us, we are sharing ideas, opinions, values, goals, and feelings with each other. This sharing is what we mean by communication.

There are two basic forms of communication: written and oral.

Oral communication is the form we are focusing on in this course. It involves speaking and listening. Implicit in oral communication is the concept of interaction which means that two or more persons talk, listen, and respond to one another.

At least two persons are involved in oral communication: the speaker and the listener.

What are the terms we use to designate these persons in the communication process?

FLIP CHART

Sender
Receiver

The sender is the person from whom the message originates. It is the person who speaks the message.

Who is the receiver?

The receiver is the person who listens to the message.

Oral communication, then, is an interactive process which involves at least two people: the sender and the receiver. Most of the time, each person is both a sender and receiver. Frequently, there are multiple senders and receivers.

There are several actions that take place in every oral communication. What are they?

FLIP CHART

One person (the sender) initiates a message.

Another person (the receiver) listens to and observes the sender.

The receiver receives and decodes the message.

The receiver gives feedback (responds) to the sender.

Look at this list that we've put on the flip chart. Based on the actions of the sender and the receiver, which person has the greater role and responsibility in the communication process?

FLIP CHART

The listener

Effective communication depends not so much on talking as it does on listening. Good communication does require the application of principles of verbal and nonverbal communication, but attention to these alone without consideration for the importance of listening, will not result in improved communication.

We cannot, however, allow the receiver the take all the credit for effective communication or all the blame for ineffective communication. The sender does have a big responsibility. The effectiveness of a person's communication depends to a large extent on the sender's ability to define the purpose of the interaction and to display self-confidence in the worth of the information that is being sent.

We'll look at this concept in more detail a little later.

Successful tuberculosis interviews, investigations, and compliance influencing activities are dependent on a health care provider's communicating effectively with clients. The way we communicate with others promotes positive or negative interactions. This course focuses on development and refinement of skills that promote positive interactions between us and our clients.

INSTRUCTOR NOTES	LESSON PLAN
VERBAL/NONVERBAL Time: ____________	
	What are the kinds of messages that we send when we communicate orally?
FLIP CHART	Verbal messages Nonverbal messages
	Verbal messages are our spoken words. Someone give us another term for "nonverbal messages." Body language. Nonverbal messages are those messages we send to others with our bodies, even if we are not sending a verbal message. Nonverbal messages are powerful messages, perhaps more powerful than verbal messages, and their meanings are usually unmistakably clear to the receiver. Let's list on the flip chart some examples of body language. Someone give us an example of body language and tell us what it means.
FLIP CHART List examples given by participants. These are some they will probably give.	

Smile	Happiness, pleasure
Frown	Anger, displeasure
Raised eyebrow	Suspicion
Grimace	Pain
Fist	Hostility
Wink	Tease, flirt
Hunched shoulders	Low self-esteem

Because body language "packs a big punch" in communication, it's important that we use the kinds of body language that send positive messages.

It is equally important for nonverbal messages to be consistent with our verbal messages. Verbal and nonverbal messages are exchanged in every communication. Communication is ineffective if the sender gives mixed or inconsistent verbal and nonverbal messages. To communicate effectively, our words and body language must not be in conflict.

I am going to send you some verbal messages now. For each message, someone give us an example, using body language, of a corresponding consistent nonverbal message and someone else give us an example of an inconsistent nonverbal message.

Use the examples provided if participants have trouble thinking up some.

Verbal: "Good bye."
Examples
Nonverbal consistent: Waving hand
Nonverbal inconsistent: Moving fingers, thumb on tip of nose

Verbal: "I believe you."
Examples
Nonverbal consistent: Smile, eye contact
Nonverbal inconsistent: Smirky grin with eyes rolled upward

Verbal: "I'm interested."
Examples
Nonverbal consistent: Leaning forward
Nonverbal inconsistent: Tapping fingers, looking around

Verbal: "I like your perfume."
Examples
Nonverbal consistent: Coming closer, savoring the fragrance
Nonverbal inconsistent: Turning away, gagging

To increase the effectiveness of your communication, always be sure to send nonverbal messages that are consistent with your verbal messages.

There is another very important point to remember about nonverbal communication:

> The receiver gets one or more nonverbal messages from the sender before the sender says the first word.

Nonverbal messages are sent throughout the course of every interaction. The first message the receiver gets from the sender is a nonverbal one, and the receiver's first impression, and perhaps lasting impression, of the sender, is based on that initial nonverbal message. People respond to the perceptions they have of others before the verbal communication begins. In every interaction, the initial nonverbal messages and others that are sent during the exchange are the "music to which the words are set."

Earlier we said that it is important to use the kinds of body language that send positive nonverbal messages.

What are some examples of body language that send negative nonverbal messages?

Use the examples provided if participants have trouble coming up with their own.

Examples
Arms crossed
Stiff neck and upper body
Sitting behind a desk
No eye contact

What are some examples of body language that send positive nonverbal messages?

Examples
Open body stance, relaxed
Sitting in chair facing each other
Eye contact

Let's take a look at the characteristics of nonverbal communication. Turn to the page in your Guide where these are listed.

Eye contact

Look directly into the other person's eyes. If this is difficult to do, focus your gaze a little below or between the eyes. Ask yourself from time to time, "Where are my eyes?" If your gaze drifts, the person you are speaking with will get a message that you are not listening.

Facial responses

Ask yourself, "What's my mouth doing now?" You can lift spirits and maintain the attention of another person by projecting a smile at the appropriate times. Just as every sentence ends with a period, dot your own conversations with a smile.

Posture

Ramrod straight is not appropriate, but neither is slumping or slouching. Practice good posture, and learn to move your head, arms, and legs naturally. Stand straight, sit straight, and walk tall to convey that you are a positive person who is interested in the other person.

Body orientation

Be approachable. Don't back away or sidestep. Stand or sit directly across from or beside the other person. Avoid placing physical barriers, e.g., a desk, between you and the other person, and guard against erecting other "barriers" such as folded arms, crossed legs, hand over mouth, etc.

Distance

Sit or stand a comfortable distance away from the other person.

< 18 inches = Intimate
18 inches - 4 feet = Close social
4 feet - 12 feet = Social
> 12 feet = Public

Effective communication with clients is essential to all we do in tuberculosis control. Successful interviews, investigations, and activities to influence compliance require the use of good verbal and nonverbal communication skills.

We have talked a lot about nonverbal communication. Now let's consider verbal communication by looking at some of the principles. Please turn to that page in your Guide.

Be brief

A message that is expressed in a few words - one that is concise - stands a greater chance of being heard, understood, and remembered by the receiver than a message that is long and drawn out. Remember, Lincoln's "Gettysburg Address" was very short and written on a letter envelope.

Be organized

A message that is arranged into an orderly, coherent whole is more easily understood than one that is disintegrated. Receivers lose interest in the message if they have to work too hard to figure out what the sender is saying.

Be enthusiastic

A message that is presented with a sense of importance (excitement or urgency) catches the ear, and the mind, of the receiver. Most people find it hard to get excited about something if the person presenting it acts as if it is not important. Show others that the information you are communicating is important by displaying confidence and enthusiasm. Believe in what you say.

Repeat yourself

A message (or parts of a message) that is repeated - reiterated - is more likely to be received than one that is stated only once. Learning is based on repetition; reinforce your most important points.

Be specific

A message that is accurate and has special meaning for the receiver stands a better chance of being fully received than a message to which the person cannot relate. A person who is thinking about buying a new car is more apt to watch the TV car commercials rather than the commercials for riding lawn mowers. In our work, we must consider the personal and cultural meanings and beliefs that influence our clients' health-related actions.

We're going to do a little excercise now to demonstrate and practice these principles

ROLE PLAY

Time: ______________

Have the participants demonstrate each principle in dyad role plays. Ask them to get into pairs. Instruct them to send messages to their partners that use the principles of brevity, organization, enthusiasm, repetition, and specificity. Ask them to assign themselves as person "A" and person "B". Person "A" is the health care provider and person "B" is the TB client. Have the provider discuss the importance of coming back to the clinic for the return visit. After person "A" has sent the message, have person "B" critique the message against the principles of verbal communication. Ask them to switch roles and repeat the exercise.

Call on a few to discuss their experiences in the role play.

We can enhance the quality of our communication by applying the principles of brevity, organization, enthusiasm, repetition, and specificity in all our interactions.

Diction qualities of the sender also have a profound effect on our communication. Examples of diction qualities are speed of delivery, volume and range of voice, tone of voice, inflection, and pronunciation. Listen to yourself when you talk and pay attention to your diction. Poor diction gets in the way of effective communication. Good diction enhances communication.

INSTRUCTOR NOTES

LESSON PLAN

LISTENING

Time: ______________

We're ready now to move into a discussion of that other very important element of the communication process. Listening!

We acknowledged earlier in this session that the receiver (listener) has a very big responsibility in ensuring the effectiveness of communication. What did we say? The sender initiates a message. The receiver listens to and observes the sender, receives and decodes the message, and gives feedback (responds) to the sender. One certain way for us to improve our communication with clients is to be good listeners.

Denis Waitley, in his audiocassette tape series, "The Inner Winner," says that communication today has become the practice of two people each waiting for the other to stop talking so he or she can start talking again. Very few people really listen to the other person. They are too busy thinking about what they are going to say next. In effective communication, how we listen is much more important than how we talk. We should listen to the needs and values of others. It's not always possible or even wise to do what they want us to, but we must understand their values if the communication process is to succeed. The best way to get and keep another person's attention is not by clever talk to sell ourselves and our accomplishments. It's by getting others to talk about their accomplishments and their needs, goals, personal aspirations, and problems. Our mission in communication is to get them to talk about themselves so we can offer something they need in return.

Waitley says that the biggest mistake in the communication process is the use of these words when talking with others:

> I am; I have; I did; I went; I need;
> I'd like; Me; Mine; Myself; and I.

INSTRUCTOR NOTES | LESSON PLAN

We should always focus the conversation on the other person by saying: "What are your needs? How can I help you accomplish your goals? What can we do together to make this a win-win situation?"

And then we stop talking and listen!

Effective communicators ask questions. They draw the other person out. They ask for examples. They feed back what others have just said for clarity and understanding.

Let's take a look now at some of the principles of listening. Turn to that page in your Guide.

Listen with your whole self.

Provide nonverbal feedback through head nodding, eye contact, hand movements, good posture, a smile, etc.

Create a distraction-free environment. No phone calls, finger tapping, doodling, please.

Avoid selective listening. Others know when you are faking attention.

Repeat and rephrase what you hear.

Draw the other person out by showing that you are listening. Give verbal feedback by paraphrasing, restating, summing up what the other person has said. Mirror, repeat his/her exact words. Say: "Tell me more." "I understand." Ask: "Why?" "How?" What?" "When?" "Who?" "Where?"

Develop sensitivity for what is left unsaid.

Listen not only to the words but also for the "real" message. Listen for hidden fear, hurt, embarrassment, frustration, concern, etc. behind the words.

Make use of the thought/speed-speech/speed ratio.

Most people talk at a speed of about 125 words per minute and think at about four times that rate (500 words per minute). Thus we have about 400 words of thinking time to spare during each minute a person talks to us. Poor listeners use this time to daydream or think about something else. Good listeners use the time to think about what has been said and plan a response.

The secret to effective communication is to bring the other person over to our side. Feeling valued and important are probably the most fundamental of human emotional needs. We can bring out these feelings in others, our tuberculosis clients, by truly listening to them.

Learning is our ultimate objective in the communication process with our clients. Through effective communication with clients, we learn information about them which we can use to help them with their tuberculosis problem or risk and information we can use to help protect others. Clients learn from us about tuberculosis and are more likely to be compliant with therapy and cooperative in contact investigation.

When we use effective communication techniques with our clients, learning takes place, and we indeed can "bring them over to our side."

It's a good idea to use visual aids and handouts to enhance communication with and learning of our clients. Many patient-oriented materials on tuberculosis are available, and we should always remember to use them.

INSTRUCTOR NOTES	LESSON PLAN
WRAPUP Time: ______________	In this session we have talked about some of the ways we can communicate effectively with others. We spend a large proportion of our time communicating with clients. It's very important in tuberculosis control that we communicate effectively with them using the principles and techniques presented in this session. I would like for you to practice using these techniques throughout the remainder of the course in class and in all of your other interactions outside of class.
ROLE PLAY Time: ______________	Let's have some fun now with what we've just learned. We're going to do an exercise which will allow you to practice the communication principles presented in this session.
Arrange the participants in several groups of four or five persons per group. Have the members of each group count off from 1 through 4 or 5. Call all persons who are Number 1 to the front or side of the room. Be careful that other group members do not hear you. Inform the Number 1's that you (the sender) are going to communicate a verbal message to them (the receivers). Tell them that you can give them the complete message only once. Do not repeat the message, but you may answer questions they might have	

INSTRUCTOR NOTES	LESSON PLAN
about the message. Then communicate one of the following two messages. Instruct the Number 1's to communicate this message to the Number 2 in their group. Number 2's are then to communicate the message to the Number 3's and so on until the last person has received the message. Do not give any information or instructions to anyone except the Number 1's.	
MESSAGE # 1	The sputum specimen that we obtained from you in the clinic yesterday has been tested in the laboratory and I received the report this morning. The laboratory found acid fast bacilli in your sputum. This may mean that you have TB. Please come back to the clinic tomorrow for an appointment with the doctor. The nurse will also read your skin test while you are there. The doctor will be in the clinic from 8:00 to noon. Your appointment is for 8:30. If transportation is a problem for you, let me know now and I will give you some bus tokens.
MESSAGE # 2	Tuberculosis is a disease caused by germs known as tubercle bacilli. A person who has pulmonary tuberculosis has tubercle bacilli in his lungs. If this person is not on treatment and is coughing, tubercle bacilli can get out of the lungs into the room air. Other people who share that same airspace can then breathe the germs into their lungs and become infected. Not all people exposed to tubercle bacilli become infected; in fact, only 30-35 percent do. Only 5-10 percent of infected people develop the disease. The only way to know for sure if you are infected with tubercle bacilli is to have a tuberculin skin test.
When all groups have finished, ask the last person in each group to stand and give the message to the entire class.	

INSTRUCTOR NOTES	LESSON PLAN
Communicate to the class the message you had given to the Number 1's and get them to discuss how close (or far away) the final message in each group was from the original.	
Generate a discussion of this communication exercise vis-a-vis the principles presented in this session.	
	Successful tuberculosis interviews, investigations, and compliance influencing activities are dependent on our communicating effectively with clients. Let's put our communication skills to work for ourselves and for our clients.
Complete and tape to the wall flip chart sheets summarizing key points, principles, and techniques discussed during this session.	

CHARACTERISTICS OF NONVERBAL COMMUNICATION

EYE CONTACT

FACIAL RESPONSES

POSTURE

BODY ORIENTATION

DISTANCE

PRINCIPLES OF VERBAL COMMUNICATION

BE BRIEF

BE ORGANIZED

BE ENTHUSIASTIC

REPEAT YOURSELF

BE SPECIFIC

PRINCIPLES OF LISTENING

LISTEN WITH YOUR WHOLE SELF

REPEAT AND REPHRASE WHAT YOU HEAR

DEVELOP SENSITIVITY FOR WHAT IS LEFT UNSAID

MAKE USE OF THE THOUGHT-SPEED/SPEECH-SPEED RATIO

Assertiveness

PART I: BASIC CONCEPTS

ASSERTIVENESS

ASSERTIVENESS

TIME: 45 MINUTES

MATERIALS/EQUIPMENT

Flip chart

Handout: Assertive-Aggressive Role Play Exercise

SUGGESTED READING FOR PARTICIPANTS

Fensterhem H. Don't say yes when you what to say no. New York: Dell Publishing Co., Inc., 1975.

Galassi MD, Galassi J. Assert yourself. New York: Human Sciences Press, 1977.

REQUIRED READING FOR PARTICIPANTS

Participant Guide material for this session.

OBJECTIVE

Participants will be able to respond assertively and thus will become more effective communicators with clients and coworkers.

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INSTRUCTOR NOTES | LESSON PLAN

INTRODUCTION
Time: ____________

During these next 45 minutes, we are going to be considering assertiveness.

When we combine assertive behavior with the principles of communication we reviewed in the last session, we come up with a very powerful way to interact with others. Assertiveness promotes positive interactions. It makes all our relationships - with clients, family, friends, and others - more effective.

I encourage you to read more on the topic to expand your knowledge and skills. Every library and bookstore has a wealth of information available for your use. Even though we are taking a "broad brush" approach to assertiveness, we are looking at the specific ways we can improve our interactions with clients so that our interviews, investigations, and compliance influencing activities are as effective as they can be.

To discuss assertiveness, there are two other terms that we need to know. These are words that describe communication styles that are not assertive.

FLIP CHART

Nonassertiveness
Aggressiveness

Nonassertiveness, aggressiveness, and assertiveness. What do these terms mean to you?

Allow time for a brief discussion. Help clarify when necessary.

INSTRUCTOR NOTES	LESSON PLAN
	The various responsibilities of TB health care providers often place us in situations with clients (and coworkers) which require assertive responses. Many of these situations test our commitment to our mission and purpose. Have you ever felt completely frustrated or angry because a patient you are working with is noncompliant with therapy, or fails to keep a clinic appointment, or breaks a promise to meet you at a certain time and place for directly observed therapy? Did you feel like "giving him or her a piece of your mind" the next time? Have you ever felt taken advantage of by a coworker or treated unfairly by a supervisor? I suppose we have all had these experiences from time to time. It's at times like these that our true professional nature and strong interpersonal qualities are put to the test. How we respond, whether nonassertively, aggressively, or assertively determines the outcome of the interaction. Again, assertive responses promote a positive interaction.
NONASSERTIVENESS, AGGRESSIVENESS, ASSERTIVENESS Time: ______________	Let's think about nonassertiveness, aggressiveness, and assertiveness for a few minutes. Your Guide has pages with the definitions of these terms. Nonassertiveness: To relinquish one's rights and/or position to others. What does this suggest to you?
FLIP CHART Encourage discussion. Draw out descriptive terms such as: shy, timid, afraid, passive, submissive, resigned, meek, mild, subdued, deferential, docile, subservient. List the terms on the flip chart.	

INSTRUCTOR NOTES	LESSON PLAN
	Nonassertiveness is associated with "too little too late or never." Being nonassertive is an invitation to others to take advantage or control. It has a definite negative emotional impact on an individual. Some of the emotions commonly experienced (internalized) by one who is nonassertive are fear, anxiety, guilt, depression, nervousness, and hurt. There are identifiable nonverbal "giveaways" of nonassertiveness such as downcast, darting, or teary eyes; slumped body, rounded shoulders, shuffled walk; hand wringing, lip biting, and nervous gestures. There are also verbal "giveaways" such as rambling statements; qualifiers ("maybe," "I wonder if you could/only/just..."); fillers ("Uh," "Well," You know"); and negatives ("Don't bother," "It's not really important").
	Some of the effects of nonassertiveness on the nonassertive person are interpersonal conflicts, depression, helplessness, poor self-image, hurting self, lost opportunities, stress, feeling out of control, disliking self and others, loneliness, and feeling angry. Nonassertiveness breeds a vicious cycle of low self-esteem, lack of self-confidence, and increased nonassertiveness.
	Aggressiveness: To demand one's rights and/or position at the expense of others.
	What does this suggest to you?
Involve participants in a discussion. Elicit discriptors such as: combative, offensive, attack, push, fight, assault, drive. List terms on the flip chart.	
	Aggressiveness is "too much too soon or too late." Aggressiveness is overriding the other person's feelings, wishes, plans, goals, preferences, etc. in order to gain one's objective. It's a certain way to "win enemies and influence people negatively." Some of the emotions externalized by aggressive persons are inappropriate anger, rage, hate or misplaced

hostility, righteousness, superiority secondary to fear, guilt, and hurt. Nonverbal "giveaways" include glaring, narrowed, expressionless eyes; stiff posture; clenched fists, jerky movements, finger pointing, hands on hips; raised, snickering, haughty tone of voice. Some verbal "giveaways" are clipped, interrupting statements; threats ("You'd better watch out," "If you don't watch out, I'll _______,"); name-calling; demanding; accusing put downs ("Come on," "You must be kidding"); judgmental, sarcastic evaluative comments.

Interpersonal conflicts, guilt, frustration, poor self-image, hurting others, lost opportunities, stress, feeling out of control, dislike of others, loneliness, and feeling angry are some of the effects of aggressiveness on the aggressive person.

Assertiveness: To claim and maintain one's rights and/or position without compromising the rights of others.

What does this suggest to you?

Draw out descriptive terms such as: positive, bold, confident, considerate.

Assertiveness is "enough of the appropriate behaviors at the right time." Assertiveness is a way of relating to others on the basis of mutual respect. It promotes a sense of dignity and worth in the other person, and results in a positive relationship. An assertive person is confident and has self-esteem, two of the most powerful determinants of an individual's ability to establish and maintain healthy relationships with others. Nonverbal "giveaways" of an assertive person are open, direct eye contact; standing and sitting comfortably straight and steady; relaxed with hands loosely at sides; strong, steady, firm, clear tone of voice. Some of the verbal "giveaways" are concise statements; "I" statements ("I think/I feel/I want"); cooperative words ("Let's", "How can we...?"; empathetic statements of interest ("What do you think?" "What do you see?").

What are the some of the effects of assertiveness? An assertive person solves problems, feels good about others, feels satisfied, feels good about self, is good to self and others, creates and makes the most of opportunities, is relaxed, feels in control of self, and likes self and others.

People are not born with assertiveness skills. We learn these skills. The more we practice them, the better we become at being assertive. The better we become at being assertive, the more effective our interactions with others become.

The difference between assertiveness and aggressiveness is less clear to some people than the difference between assertiveness and nonassertiveness. Let's use two examples to draw the distinction between assertive and aggressive. I will first make an aggressive statement. Then I'd like you to convert the message in that statement to one that is assertive.

Aggressive statement: How can you be so disgusting and insensitive by smoking in here with these good people!

CALL ON PARTICIPANT(S)

Give us the message assertively.

Provide the assertive statement if the class has not in essence already given it.

Assertive statement: Although you have the right to smoke outside in the lobby, your smoking is not permitted in this room because it will bother the other people.

Did you hear (feel) the difference between the aggressive and the assertive statements?

Here's another one.

INSTRUCTOR NOTES	LESSON PLAN
	Aggressive statement: You're not listening to me! How do you expect to hear the important information I have to give you if you don't pay attention?
CALL ON PARTICIPANT(S)	How would you give this message assertively?
Provide the assertive statement if the class has not in essence already given it.	Assertive statement: I feel we are not communicating well. Let's concentrate for a few more minutes, and we'll be able to share some important information.
	Did you hear (feel) the difference in these statements?
	If these statements were actually made to you in the "real world," which do you think would evoke good feelings and a positive response in you?
	If you made these statements to one of your TB clients, which do you think would promote a positive relationship between you and that person?
	Assertiveness is a way of relating to others on the basis of respect.
FLIP CHART	There is a formula for assertiveness which has "respect" in it.
Write the formula on the flip chart.	(R) + (R) + (S) = (A) R = Respect for others R = Respect for oneself S = Specificity in communication A = Assertiveness

You can use this formula to check yourself out when interacting with others. From time to time, ask yourself: "Am I showing respect for this person? Am I showing respect for myself? Am I being specific in what I'm communicating?" If you can answer "yes" to all three questions, you are acting assertively and thus you are promoting a positive relationship.

Some of the important ingredients needed for effective, assertive communication are:

Personal self-confidence. Self-confidence comes from having knowledge about the subject (topic) and successfully using that knowledge. When interacting with clients, know your subject!

Understanding of the purpose and value of the interaction. Know without any element of doubt that your relationship with the client and what you are doing and communicating have purpose and value for the client and others in the community.

Belief in the interaction. Demonstrate your belief in the importance of the interaction to the client's health and well-being. Sincerely want the best for the client and work to accomplish it.

INSTRUCTOR NOTES	LESSON PLAN

ROLE PLAY
Time: ______________

Have participants break into groups of three. In each group, assign one player to be:

The client
The health care provider
The observer

HANDOUT

Assertive-Aggressive Role Play Exercise

Go over the scenario. Be certain everyone knows which of the three parts he/she is playing.

Instruct the health care providers in half of the groups to be aggressive; the health care providers in the remaining groups to be assertive. Be certain to clearly designate which groups are aggressive and which groups are assertive.

Tell the participants not to let the exercise devolve into a caricature.

Allow the role plays to go for three or four minutes. Call on an observer from an aggressive group and an observer from an assertive group to report their observations of provider and client. Call on one or two clients to describe their feelings and responses to

INSTRUCTOR NOTES

LESSON PLAN

aggressiveness and assertiveness. Encourage a brief discussion highlighting principles of communication and assertiveness.

WRAPUP
Time: ____________

Assertiveness comes from believing in oneself (having self-confidence) and is the act of executing that belief in a way that the other person can tell that you understand the purpose and value of the interaction. When we are assertive, we respect ourselves and others, and we communicate in specific terms. We claim and maintain our rights or position without compromising the rights of others. Assertiveness promotes positive, effective relationships. We can and should use our assertiveness skills to increase our interviewing, investigating, and compliance influencing responsibilities in tuberculosis control.

Complete and tape to the wall flip chart sheets summarizing key points of the session.

NONASSERTIVENESS:	To give up one's rights and/or position to others.
AGGRESSIVENESS:	To demand one's rights and/or position at the expense of others.
ASSERTIVENESS:	To claim and maintain one's rights and/or position without compromising the rights of others.

THE ASSERTIVE APPROACH

PERSONAL SELF-CONFIDENCE

UNDERSTANDING THE PURPOSE AND VALUE OF THE INTERACTION

BELIEF IN THE INTERACTION

ASSERTIVENESS

HANDOUT

Assertive-Aggressive Role Play Exercise

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ASSERTIVE-AGGRESSIVE ROLE PLAY

The Scenario

Client

You don't believe you have TB even though you have been coughing and losing weight for five weeks. You think the doctor at the clinic doesn't know what she's talking about, and you are not taking the medicine she prescribed. You have three small children living with you. They have had tuberculin skin tests which have not been read. You don't see the need to take them back to have the tests read, since you don't believe you have TB and they aren't sick.

Health care provider

You have been assigned to make a home visit to a bacteriologically confirmed pulmonary tuberculosis patient who is suspected of being noncompliant in taking prescribed medicine. The patient has not kept scheduled clinic appointments. Three small children live in the home with the patient. They have been given tuberculin skin tests, but were not returned to the clinic to have the tests read.

Your job is to assess the situation, find out if the patient is taking the prescribed drugs, and get the patient to bring the children back to the clinic for examination.

Observer

Your job is to watch the interaction. Observe the health care provider. Notice his/her verbal and nonverbal communication. Watch and listen to him/her interact aggressively or assertively with the client. Observe the client for reactions to the aggressive or assertive communication.

Introduction to Interviewing

PART I: BASIC CONCEPTS

INTRODUCTION TO INTERVIEWING

INTRODUCTION TO INTERVIEWING

TIME: 60 MINUTES

MATERIALS/EQUIPMENT

Flip chart

Handout: Brief Tuberculosis Interview Outline

NOTE

An introduction to interviewing is presented in Part I so that TB health care providers who are not responsible for "formal" interviews with patients may learn some of the basic principles which can be applied in their investigative roles. The techniques of asking questions covered in this session are useful to persons who do field work as well as to those who conduct formal interviews with patients. Be certain that participants who are taking only Parts I and III understand this and are not misled into thinking they are being trained to become interviewers.

REQUIRED READING FOR PARTICIPANTS

Participant Guide material for this session.

OBJECTIVE

Participants will be able to ask open-ended questions.

INSTRUCTOR NOTES | **LESSON PLAN**

INTRODUCTION
Time: ________________

This session is devoted to an introduction to interviewing.

Interviewing is an integral activity in tuberculosis control. We perform interviews with our clients and with other persons daily. We may not always think of the conversations we have with clients as interviews, but most of them are. An interview is not a casual, impromptu speaking situation. On the contrary, it is a situation which requires considerable knowledge and skill.

Effective relationships are dependent upon a positive interaction between individuals. In the previous sessions, we discussed how we can use communication and assertiveness skills to enhance interactions with our tuberculosis clients. In this session we are going to consider how we can use the interview to help make our interactions with clients more effective.

FLIP CHART

> A tuberculosis interview is an individualized exchange of information between a health care provider and a client.

The key word is "exchange." Information flow in an interview must be two way. We make a critical mistake if we conduct an interview in which the information flow is one way. Such a mistake will render the interview ineffective. We exchange information with the client. That is to say, we obtain information from and impart information to the client.

TB health care providers of all disciplines interview clients. Interview information is the basis for diagnosis, treatment, followup, contact investigation, and prevention - literally, for all we do in tuberculosis control. The interview skills taught in this course are focused on imparting and obtaining information that can be used to influence compliance behaviors and ensure the referral, examination, and preventive treatment of contacts.

INSTRUCTOR NOTES	LESSON PLAN
FLIP CHART	What are some of the categories of information that we need to obtain when we work with tuberculosis clients?
List responses on the flipchart. Some that you are looking for are:	Personal (e.g., name, age, address, phone number, marital status) Knowledge/understanding of tuberculosis History and symptoms Household environment Work or school environment Leisure activities Names and addresses of contacts
FLIP CHART	What are some of the categories of information that we want to impart to clients?
List responses on the flipchart. Some that you are looking for are:	Details of disease/infection Results of tests/examination Drugs prescribed Drug side effects Cover cough/vent room Clinic appointments Clinic hours Followup tests/examinations Protecting others
	So, there is a variety of information that we need to get from and give to clients. The specific kinds of information, of course, depends on the type of client, i.e., patient, contact, suspect, converter, etc. Sometimes we conduct interviews with persons who are not actually clients. We'll call these people third parties. Examples are a client's neighbors or landlord, a bartender, local business operators, the mailperson, and others who we speak with from time to time while we are working with a client.

INSTRUCTOR NOTES	LESSON PLAN
	Irrespective of whom we are talking with, the techniques for conducting the interview are the same.
	Let's talk now about one of the basic skills of interviewing: asking questions. Each of us has asked questions all of our lives, and on the basis of experience, we should be pretty good at it. However, in interviewing there is a right way and a wrong way to ask questions. When we combine asking questions the right way with our good communication and assertiveness skills, we can increase the effectiveness of our interviews. You are probably asking yourself "What is the right way to ask questions?" That's a good question. The answer is found in the types of questions we can ask. There are at least two types of questions.
FLIP CHART	Open-ended questions (right way) Close-ended questions (wrong way)
	Close-ended questions elicit specific responses and ask the other person for nothing beyond agreement or disagreement. They can be answered by "yes" or "no." Close-ended questions do not promote a dialogue between the interviewer and the client. The result is a one way flow of information. Here are some examples of close-ended questions.
FLIP CHART Write only the close-ended questions on the chart. Do this in advance.	

INSTRUCTOR NOTES

LESSON PLAN

Close-ended (Bad)	Open-ended (Good)
Are you Jake Buckner?	Who is Jake Buckner?
Do you have the time?	What time is it?
Do you know when Jake will arrive?	When will Jake arrive?
Is First Avenue around here?	Where is First Avenue?
Do you know how to get to Jake's house?	How do I get to Jake's house?
Would you tell me why Jake did that?	Why did Jake do that?

What is the characteristic that is common to all of these close-ended questions?

CALL ON PARTICIPANT(S)

They can be answered by a simple "yes" or "no." They do not promote a dialogue and two way flow of information.

Open-ended questions, on the other hand, promote answers of more than one or two words of agreement of disagreement. They cannot be answered by a simple "yes" or "no." They promote a dialogue and a two way flow of information. And that is what we want to happen when we talk with tuberculosis clients.

FLIP CHART

Let's convert the close-ended questions we have here on the flip chart to open-ended questions.

Write questions given by participants beside/below the corresponding close-ended question. Use the ones provided above if they get stumped.

It is very important in tuberculosis control that we obtain complete and accurate information from patients, suspects, contacts, and other clients (as well as third parties) in order to carry out our responsibilities of locating, referring, and providing services to them. The best way to obtain the information we need is through the use of open-ended questions.

What distinguishing characteristic do you notice in these open-ended questions?

The "trademark" of open-ended questions is this. They all begin with one of the following words:

FLIP CHART

Who
What
When
Where
Why
How

We can be sure that the questions we ask clients in an interview situation or in the field are open-ended questions by remembering to start each one with who, what, when, where, why, or how.

At times, we may have to use close-ended questions in order to get a specific piece of information. For example, "Have you been coughing?" can be answered by "yes" or "no." This question is aimed at getting specific information about symptoms. If the answer is "yes," we can followup with open-ended questions such as "When did you start coughing?" and "How much do you cough?"

Occasionally, we may want to get a specific "yes" or "no" response to a question. In these situations, we need to be aware that the way we construct the question (either positively or negatively) can have a determining effect on the answer we get. Remember this:

Positive questions invite a positive response. That is to say, you want (expect) the other person to answer "yes."

Negative questions beg for a negative response; you want (expect) "no" for an answer.

The critical thing to remember is that if you want the other person to say "yes," state the question positively, not negatively. If you want a "no" answer, state the question negatively instead of positively.

CALL ON PARTICIPANT(S)

Give us an example of a negative question. Then restate the question as a positive question.

FLIP CHART

Write several examples on the flip chart. Use the examples provided if participants need help.

Negative	Positive
You don't have a a telephone, do you?	You have a telephone, isn't that right?
You don't know why you feel sad, do you?	You know why you feel sad, don't you?
Jake isn't here, is he?	Jake is here, isn't he?
You can't tell me Jake's Jake's birthday, can you?	You can tell me Jake's birthday, right?
You haven't shared air with anyone else, have you?	You have shared air with some other people, haven't you?

Remember that both positive and negative questions do not promote a dialogue. They can be, and usually are, answered by "yes" or "no." From time to time, you may want the client to respond positively or negatively, and if so, it is appropriate to use a close-ended question, but

INSTRUCTOR NOTES	LESSON PLAN
	be certain to ask the question the correct way. State the question in such a way that you "invite" the client to respond the way you wish.
	Most of the time, however, when interviewing clients and others, it is best to use open-ended questions. In our examples of positive/negative questions, the questions can be changed to open-ended questions that cannot be answered simply by "yes" or "no."
CALL ON PARTICIPANT(S)	Change the positive/negative questions we came up with earlier to open-ended questions.
These are the changes for the examples given above. If participants gave different examples, make the changes in those.	What is your telephone number? Why do you feel sad? Where is Jake? When is Jake's birthday? Who else have you shared air with?
ROLE PLAY Time: ________________	We're going to do an exercise now which will enable you to practice asking questions. This exercise will permit you to experience for yourself the importance -- and the difficulty -- of using open-ended questions.
Ask participants to get into pairs.	

INSTRUCTOR NOTES

In this exercise, participants are to use open-ended questions to obtain information about each other. The information will then be used by participants to introduce their partner to the entire class.

Instruct participants to designate themselves as "A" or "B" in each pair. First, "A" will interview "B", then "B" will interview "A". Allow about 3 minutes for each interview.

Ask the interviewees to respond to any close-ended questions of the inter viewer with an emphatic "yes" or "no" only.

Instruct the participants to interview their partner (TIME: 3 minutes each). Using the information obtained in the interview, interviewers will prepare to introduce their partner to the group.

FLIP CHART

Ask participants to be able to present the following information about their partner:

LESSON PLAN

Name

Area of assignment

Length of time in the program

Duties and responsibilities

Most unusual job-related experience

Personal information as appropriate

INTER-9

When the interview time period is over, start at one end of the table and ask "A" to stand and introduce "B". Allow 30-60 seconds for each introduction. Then ask "B" to stand and and introduce "A". Proceed until all participants have been introduced.

DISCUSSION
Time: ______________

Generate a discussion about the exercise by asking the questions given.

How many of you "caught" yourself or your interviewer using a close-ended question? Describe.

Why are open-ended questions better than close-ended questions in an interview? What are your feelings about how easy or difficult it was to use open-ended questions?

Interviewers, what did you observe about the listening skills of your partner?

Interviewees, what did you notice about your interviewer's verbal and nonverbal communication skills? What about assertiveness skills?

What in this exercise environment made interviewing easier or harder than it is on the job?

WRAPUP
Time: ____________

Talking with, or interviewing, clients and other people for the purpose of obtaining and imparting information constitutes a very important part of our job in tuberculosis control. We can be more effective in the information exchange if we apply the principles of communication and assertiveness that we reviewed earlier and if we pose our questions in such a way as to promote a

INSTRUCTOR NOTES	LESSON PLAN
	dialogue. The way to promote a dialogue is to ask open-ended questions. We must remember, too, to practice good listening skills after we have asked the open-ended questions.
	Throughout the remainder of the course, we will be emphasizing open-ended questions. Practice using them each time you ask a question in class and in all of your interactions out of class.
HANDOUT Brief Tuberculosis Interview Outline	I'm going to give you an outline for a tuberculosis interview which can be used as a framework for developing open-ended questions to obtain and impart information when we interview tuberculosis patients. Keep this handy, because we will need it again later in the course.
Distribute the handout.	
Complete and tape to the wall flip chart sheets summarizing key points of the session.	

INTRODUCTION TO INTERVIEWING

HANDOUT

Brief Tuberculosis Interview Outline

BRIEF TUBERCULOSIS INTERVIEW OUTLINE

I. Introduction

II. Body

  A. Patient Assessment

    1. Physical observation
    2. Patient concerns
    3. Personal information
    4. Medical history and disease comprehension

  B. Transmission Interruption Behaviors

    1. Take medication
    2. Cover cough
    3. Return for prescription refills, followup examinations, and medical evaluations

  C. Contact Investigation

    1. Introduction of the process
    2. Contact identification
      a. Household environment contacts
      b. Work/school environment contact
      c. Leisure environment contacts
    3. Methods of referral

III. Conclusion

  1. Questions and answers
  2. Summary of main points

IV. Followup

  1. Plan for next interaction

DHHS:PHS:CDC:CPS:DTBC:9/87

Problem Solving

PART I: BASIC CONCEPTS

PROBLEM SOLVING

PROBLEM SOLVING

TIME: 45 MINUTES

MATERIALS/EQUIPMENT

Flip chart

REQUIRED READING FOR PARTICIPANTS

Participant Guide material for this session.

OBJECTIVE

Participants will be able to apply the basic problem solving steps.

INTRODUCTION
Time: ____ __________

This session is about problems and problem solving.

TB health care providers encounter problems routinely in our interactions with clients. Problems can emerge in virtually any provider/client interaction. When problems surface, we must deal with them; otherwise, we will not be able to carry out the responsibilities of our jobs. In this session, we will be introduced to an effective method for solving problems in our interactions with tuberculosis clients.

CALL ON PARTICIPANT(S)

How do you define "problem?"

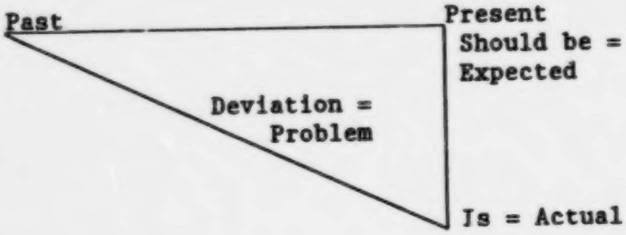
FLIP CHART

This is how we define "problem."

> A problem is a deviation between what is expected (the "should be") and what is actually happening (the "is").

Diagram the definition on the flip chart.

To better understand this definition of a problem, look at this diagram.



A problem is a deviation between the way things should be and the way they actually are.

Here are some examples (use two or three):

Your car had been averaging 30 miles per gallon of gasoline since you bought it two years ago. Over the past two weeks, you have noticed that it is averaging only 19 miles per gallon of gasoline. A problem exists, because there is a deviation between what is expected (the "should be," i.e., 30 mpg) and what is actually happening (the "is," i.e., 19 mpg).

CALL ON PARTICIPANT

A patient who has been keeping clinic appointments regularly for four months did not come to clinic yesterday as scheduled. Is there a problem?

Yes, there is a deviation between what is expected and what actually happened.

CALL ON PARTICIPANT

A patient who has met you twice a week for the past six weeks for directly observed therapy does not show up at the designated place on Monday or Thursday this week. Is there a problem?

In each of the examples, there is a deviation between the "should be" and the "is."

CALL ON PARTICIPANT(S)

Why are we concerned when problems arise in the course of our interactions with clients?

We're concerned because problems get in the way of our mission. They interfere with accomplishing our goals and objectives for individual clients and for the program as a whole.

If a patient does not take medications as prescribed, fails to keep clinic appointments, or is not cooperative in contact investigation, there is a deviation between what should be happening and what is actually happening. There is a problem. The problem is getting in the way of our tuberculosis control mission. Problems must be solved. Our problem solving efforts, then, are focused on patient behaviors which are not consistent with appropriate (expected) personal and public health practices that are necessary for the prevention and control of tuberculosis. In order to solve problems, we first must recognize their existence. Therefore, on-going assessment of our relationship with the client and problem solving go together.

PROBLEM SOLVING METHOD

Time:

Problem solving involves three basic steps. Turn to the problem solving steps page in your *Guide*.

It's important to to take *each* of the steps with every problem that arises in your interactions with a client. The three steps are:

Identifying the symptoms.
Diagnosing the problem.
Implementing a solution.

Let's look at these more closely.

Identifying the symptoms

If a problem exists, symptoms of the problem eventually come to the surface. For example, a mother notices that her normally active two-year old child is becoming lethargic and irritable. The child's face feels hot when she touches it. She takes his temperature, and the reading on the thermometer is 103 F. The elevated temperature, even though it may be considered a problem in and of itself (deviation), is rather a symptom of a larger problem - an illness, possibly a bacterial infection. In this situation, the elevated temperature, rather than being *the* problem, is a symptom of *a* problem.

Listen and look for symptoms of problems in interactions with clients. The best way to do this is to be sure that the information flow is two way. Open-ended questions promote a two way flow of information and thus draw out symptoms of a problem. Listen carefully to the client's responses to questions and observe body language closely.

Examples of problem symptoms might be the patient's restlessness in the interview room, hesitancy to answer specific questions about contacts, and emotions such as fear and embarrassment.

Symptoms can also surface in ways other than direct interaction. Bacteriology that does not convert to negative after a month or two of treatment and failure to keep appointments are examples. These symptoms suggest that something is happening (or not happening) which represents a deviation from what is expected.

Diagnosing the problem

Once the symptoms of a problem have been identified, the next step is to hone in on the specific problem. The best way to do this is by asking appropriate questions, listening carefully to the responses, and analyzing the feedback. This is the most productive approach to gaining insight into the client's perception of the situation and plan for handling it. The use of open-ended questions and the application of good communication skills, especially listening, are crucial.

The mother of the two-year old might ask, "Where does it hurt?" or "How do you feel?" We might say to the client, "I notice you seem to be uncomfortable when we talk about persons outside your family that you have shared air with? Why does this bother you?"

Implementing a solution

Once a problem has been diagnosed, the problem solving process can begin. Before we talk about a problem solving method that works, look at the problem solving model in your Guide.

The "LOVER" model for problem solving:

L = Listen
O = Observe
V = Verify
E = Evaluate
R = Respond

This model incorporates the principles of communication that we discussed earlier. We talked about the importance of listening in the communications process. Observing body language for nonverbal messages is equally essential to gaining information from the client. Verifying means that we "check out" the information we have accumulated -the verbal and nonverbal messages- to be sure it is valid. Evaluating, in the problem solving model, means to "look at the big picture" before deciding on and implementing a solution. Listening, observing, verifying, and evaluating are tasks that we must do effectively with each client in order to identify problem symptoms and diagnose problems. Failure to attend to these tasks will diminish the effectiveness of our interactions with clients. When our interactions with clients are not effective, we build in assurances that program goals and objectives will not be met.

Look at the bottom of the problem solving model page. As you can see, the L, O, V, and E are linked to identifying symptoms and diagnosing the problem. In order to identify symptoms and diagnose the problem, we have to Listen, Observe, Verify, and Evaluate. Then, and only then, can we implement the solution which is the R of the LOVER model. R, of course, is the response.

Let's look now at a problem solving method. This is a method of responding, i.e., implementing a solution.

The problem solving method is known as confrontation.

Look at the confrontation page in your Guide.

What does the word "confrontation" suggest to you?

As a problem solving strategy, confrontation is defined as a challenge to another person to examine or change some particular aspect of his or her behavior.

Confrontation is a problem solving technique which is to be used at the point in time when a problem has been diagnosed and you are ready to begin resolving it with the client.

You may not like the term "confrontation" because it suggests aggressive behavior by the health care provider. You would be correct in this view, if we were advocating a confrontation between the provider and the client. We are not talking about your confronting the client. Instead, we are talking about confronting the problem. There is a big difference, and I ask you to keep that in mind as we move ahead. We challenge the client to confront the problem. We do this assertively, not aggressively.

There are a three forms of confrontation that are effective in solving problems in interactions with clients. These are listed in your Guide.

Present information

In a very straightforward manner, inform the client about the problem you have diagnosed. For example, you might say, "Jake, when I mentioned to you that we would need to talk about persons outside of your family that you have shared air with and might have exposed to tuberculosis germs, you became very nervous. You told me that you don't have any contacts outside of your household and place of work, yet you spend some time a couple of nights a week at the Rex Bar and Grill."

By simply presenting information, you have challenged the patient to examine or change some particular aspect of his behavior in your interaction.

Or you might say, "Jake, you have been telling me for the last month that you are taking your medicine, but your laboratory tests are still positive. It doesn't look like your tuberculosis is getting better. Most patients I work with get negative laboratory tests after taking their medicine for a month or two"

When you present the information in an assertive, nonjudgmental way, the door is opened for additional open-ended questions and dialogue.

Self-involvement

Involve the client in suggesting a way the problem can be solved. For example, "Jake, I notice you seem to be nervous about talking about all of your contacts, especially those you see at the Rex Bar and Grill. How do you suggest we do this in a way that will not make you feel uncomfortable?" Or, "Jake, I'm concerned about your latest lab test results. They're still positive. You tell me you have been taking your medicine. I'm interested to know what you think about this."

This approach lets the client know you are aware that a problem exists and offers a way for the client to become actively involved in the solution.

Suggest withdrawal of reinforcement

Indicate to the client that there are logical consequences. Say, for example, "Jake, I feel as though you don't want to talk about the people at the Rex Bar and Grill. I want to work cooperatively with you, but it's hard for me do this if you don't cooperate with me. How else can I determine if some of them need to be examined unless you or someone at the bar tells me about them?" Or, "Jake your last series of lab tests came back positive, suggesting that you are not taking the medicine as the doctor prescribed. The only way your tuberculosis will be cured is for you to take the drugs. If you don't take your medicine, you'll get worse."

With any of these three forms of confrontation, we challenge the client to examine or change some aspect of behavior in the interaction which is taking place. The client is then in a position to re-evaluate perceptions of the situation and plans for dealing with it. We are in a position to motivate the client to work with us toward a common goal.

Sometimes the symptoms of a problem may not be clearly identifiable. This makes problem diagnosis and solving more difficult. When we "sense" a problem, we may have to use our best judgment (based on experience) of what the problem is likely to be. This "fishing" is more of a "when nothing else is working" approach and essentially requires us to restate some of the previous information the patient has provided, review the patient's past behavior patterns, or to use nonspecific challenges about "the lack of responsiveness to the importance of the situation."

WRAPUP
Time: ____________

The purpose of problem solving is for the health care provider and the patient to define a common goal which can then become the basis for patient motivation.

Problem solving is a very important part of our role as TB health care providers. Problems that surface in our interactions must be solved if our interactions are to be effective. Let's quickly review some of the key points of this session.

First, careful listening, open-ended questions, and analysis of feedback provide the best approach for problem solving by confrontation with a client. Until clients believe that the consequences of not cooperating outweigh the benefits of what you are asking them to do, they are likely not to comply.

Problem solving and resultant motivation must be done on an individual patient basis. Patients will most often be motivated by positive reinforcement and appropriate confrontation. Problem solving must be developed as interactions with a patient progress. The problem solving process must begin at the time a potential problem is identified. Problems must be resolved before the health care provider and the patient can work successfully toward accomplishing a mutual goal.

Finally, we occasionally will encounter client problems which we alone cannot solve. In these instances, we should remember that we are part of

INSTRUCTOR NOTES	LESSON PLAN
	a team and call on other team members for advice and assistance. Even the most talented and experienced health care providers find it helpful to ask for a coworker's advice or assistance from time to time when working with a difficult client. The concepts taught in this session, more than any other, test our analytical and intuitive skills. We may not always be successful in resolving every problem in our interactions with clients. However, our capability, and comfortability, will increase with each actual problem we identify, diagnose, and solve using these concepts.
Complete and tape to the wall flip chart sheets summarizing key points of the session.	

PROBLEM SOLVING STEPS

IDENTIFY THE SYMPTOMS

DIAGNOSE THE PROBLEM

IMPLEMENT THE SOLUTION

A PROBLEM SOLVING MODEL

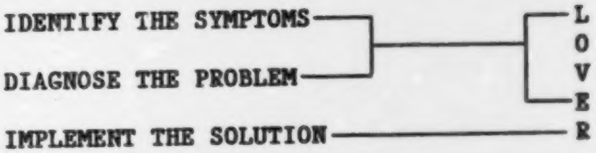
L = LISTEN

O = OBSERVE

V = VERIFY

E = EVALUATE

R = RESPOND



IDENTIFY THE SYMPTOMS

DIAGNOSE THE PROBLEM

IMPLEMENT THE SOLUTION

CONFRONTATION

Confrontation occurs when one person challenges another person to examine or change some particular aspect of his/her behavior.

FORMS OF CONFRONTATION

PRESENT INFORMATION

PROMOTE SELF-INVOLVEMENT

SUGGEST WITHDRAWAL OF REINFORCEMENT

Compliance

PART I: BASIC CONCEPTS

COMPLIANCE

DHHS:PHS:CDC:CPS:DTBC:9/87

COMPLIANCE

TIME: 45 MINUTES

MATERIALS/EQUIPMENT

Flip chart

Handout: Compliance Case Study: Luther

NOTE

The benefits of this sessions are derived primarily from the compliance exercise. In order to give participants ample time for the exercise and group reports, the lecture should be limited to 15 minutes.

REQUIRED READING FOR PARTICIPANTS

Participant Guide material for this session.

Snider DE, Hutton MD. Improving patient compliance in tuberculosis treatment programs. DDHS, PHS, CDC. 1986.

OBJECTIVE

Participants will be able to describe the strategies for improving patient compliance.

LECTURE
Time: ____________

Turn to the "Compliance" section in your *Guide* which includes the CDC booklet entitled *Improving Patient Compliance in Tuberculosis Treatment Programs*. I am going to move through the lecture very quickly, highlighting some of the material you read. We will use most of the time in this session for a compliance exercise.

Compliance is a very complex subject. To study the subject in depth would require more time than we are able to allot in this course. We will consider some of the things we can do to influence compliance in tuberculosis control. I encourage you to pursue the topic in more detail on your own. There is an excellent selected bibliography in the CDC booklet to direct you to some of the important published works.

Compliance is the practice of following instructions. It is the extent to which a person's health-related behaviors, i.e. taking medication, keeping appointments, etc., coincide with medical advice.

Noncompliance is a problem in the treatment of tuberculosis as it is in the treatment of almost all other medical conditions for which long term self-administered therapy regimens are prescribed.

Why are we concerned about noncompliance in tuberculosis control?

If patients do not take the medicines as prescribed, they won't be cured. They may continue to be infectious and spread infection to others. They may develop drug resistance and infect other people with resistant organisms. If persons who are prescribed preventive therapy are noncompliant, they and *we* may lose opportunities to prevent future cases and the subsequent spread of infection. Noncompliance gets in the way of achieving our objective of eliminating tuberculosis.

In the past, it was generally accepted that compliance was the sole responsibility of the patient. The patient simply reaped the consequences of noncompliance by not getting better, getting worse, dying, or being quarantined if the condition being treated was a communicable disease. Recently, however, we have begun to approach the issue of compliance from the point of view that the health care provider has an important role to play in influencing compliance.

Most people selectively choose what they wish to do and what they wish not to do. People tend to be more compliant with a medical recommendation if they:

Perceive it is important;

Feel capable of performing the task;

Perceive benefits from performing the task; and

Can easily assimilate the task into daily lifestyle.

Therefore, the responsibility for dealing with the problem of noncompliance is not solely the patient's. The health care provider must share that responsibility. Some of the things we are responsible for are:

Assuring that the patient has the knowledge and skills necessary for compliant behavior;

Maintaining an awareness of the "signs and symptoms" of noncompliance; and

Helping the patient identify and remove obstacles to compliant behavior.

Behaviors associated with compliance must be communicated effectively to the patient and reinforced at appropriate intervals. To do this, we need to be thoroughly familiar with the factors which have an impact on patients' responses and cooperation. Let's look now at some of the factors related to compliance. These are listed in your Guide and discussed in the booklet.

Referral process

A long interval between the time of referral and the time of actual appointment makes it less likely the patient will keep the appointment.

Clinical setting

Waiting time at the clinic, clinic hours, distance, snacks and drinks, cleanliness, etc. are determinants of appointment-keeping behavior.

Duration of treatment

Generally, compliance decreases with time. The shorter the length of treatment, the more likely the patient is to be compliant.

Number of medications prescribed

The fewer the number of medications, the greater the possibility the patient will be compliant.

Frequency of dosing

Tailoring the regimen so that drugs are taken only once daily probably enhances compliance.

Prescription labeling

Noncompliance may result from instructions that are not clearly written in words the patient understands.

Side effects

Studies do not show that side effects adversely affect compliance.

Cost

The cost of medications may influence compliance. Most areas provide tuberculosis drugs free of charge.

Safety-lock containers

"Child-proof" containers interfere with compliance of some patients such as the elderly and arthritics.

Parenteral medications

Injectable drugs enhance compliance because of the supervision that is required.

Lifestyle

Patients who lead a lifestyle that competes with establishing a regular daily drug ingestion schedule are more likely to be noncompliant.

Social support

Patients who receive support from family, friends, clinic staff, and others are more likely to be compliant.

Health beliefs

What patients believe about tuberculosis and how it affects them influences compliance.

Locus of control

Persons who feel they are not in control of their lives are more likely to be noncompliant.

Patient-health care provider interaction

Compliance can be enhanced if the patient perceives that the quality of interaction with the health care provider is good.

Patient demographics

Characteristics such as age, sex, education, income, etc. to not appear to be associated with compliance.

Features of the disease

Severity of disease and number of symptoms have not been shown to be determinants of compliance;

however, disability due to the disease is a factor. The greater the disability, the greater likelihood of compliance.

Consider now some of the strategies for improving compliance. These are also in your Guide and booklet.

Educate the patient

Explain expected compliance behaviors in specific, clear, and precise language the patient can understand. Solicit feedback and questions about instructions from the patient. Address patient concerns. Supplement verbal instructions with written instructions. Inform the patient of the results and consequences of noncompliance.

Improve appointment-keeping

Call or send a written reminder a few days before the appointment date. Immediately make a telephone call or home visit if the patient fails to come to clinic. Conduct multi-disciplinary team case (physician, clinic nurse, outreach worker, social worker, etc.) conference for patients who repeatedly break appointments.

Confront the patient's problems

Openly and clearly state the facts and your concerns about noncompliance and its effect on the patient's treatment outcome. Listen to the patient to identify barriers to compliance which can be solved. Do collaborative problem solving.

Elicit social support

Identify family members, friends, and others who can support compliance behavior of the patient.

Tailor the regimen

Structure the regimen to coincide with the patient's lifestyle. Link ingestion of drugs to a daily ritual, such as drinking morning coffee.

Behavior modification

Give verbal encouragement; reinforce "good" behaviors. Offer gifts, incentives, or awards for reaching treatment goals. Use the principle of reciprocation. Teach the patient to self-monitor pill consumption. Enter a written compliance agreement with the patient.

Use extended supervision

Use directly-observed therapy. Make home visits for pill counts, sputum collection, and urine tests. Use authorities provided for in public health laws.

CASE STUDY
Time: ______________

Have participants break into groups of four or five.

HANDOUT

Compliance Case Study: Luther

Distribute the handout.

Instruct the groups.

Each group is a team of TB health care providers. The medical director of the TB clinic is concerned about the problem of noncompliance. Luther, a patient recently diagnosed and started on therapy, is suspected of not taking his medicine. The director has asked the staff to make recommendations about what can be done to ensure that Luther takes his TB drugs.

Instruct the groups to review the case study information and then:

1. List the possible reasons for Luther's noncompliance; and
2. Come up with a list of recommendations for ensuring compliance to be discussed with the medical director.

Ask each group to select a member to be a spokesperson who will report the group's recommendations to the class.

Give the groups about 15 minutes to work.

Allow 10 minutes for as many groups as possible to present their findings and recommendations to the entire class.

WRAPUP
Time: ____________

Our study of compliance has been brief, but we have covered some of the important points. Remember that the quality of the interaction between the health care provider and the patient is a principle factor in compliance. When we apply the principles of communication, listening, and assertiveness, we can improve the quality of our interactions with clients. When we improve the quality of interactions, we have a positive influence on compliance.

Complete and tape to the wall flip chart sheets summarizing key points of the session.

COMPLIANCE

REQUIRED READING

IMPROVING PATIENT COMPLIANCE IN TUBERCULOSIS TREATMENT PROGRAMS

Dixie E. Snider, Jr., M.D., M.P.H.
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DHHS:PHS:CDC:CPS:DTBC:2/86

PREFACE

In recent years, there has been an increasing awareness of, and concern about, the problem of noncompliance with prescribed antituberculosis chemotherapy. This booklet provides a brief overview of what is known about compliance and offers suggestions for detecting and dealing with noncompliant behavior as it relates to treatment of tuberculosis and preventive therapy for tuberculous infection.

Some of the material presented was derived from an excellent book edited by Haynes, Taylor, and Sackett entitled "Compliance and Health Care" which readers may wish to consult for a more detailed and thorough review of the subject. Some of the suggestions for improving compliance are taken from published research studies; others are provided solely upon the recommendation of successful TB control workers around the country. We thank all of those who contributed their ideas and experiences during the initial writing and subsequent revisions of this booklet.

OVERVIEW AND MAGNITUDE OF THE PROBLEM OF NONCOMPLIANCE

In the past, physicians were taught that the limit of their responsibility was to diagnose and prescribe appropriate treatment for a disease. The patient was expected to assume responsibility for complying with the physician's advice. According to this view, if the patient failed to comply, he/she simply reaped the consequences (by not getting better, getting worse, dying, or if he/she had a communicable disease, being quarantined) of this "noncompliant" behavior. Today, many health care providers are approaching the issue of compliance from a fresh viewpoint: All of us selectively choose what we wish to do and wish not to do; generally, we tend to be more "compliant" with the health care provider's prescription if we (1) perceive it is important, (2) feel capable of performing the task, (3) perceive benefits from performing the task, and (4) can easily assimilate the task into our daily lifestyle. With this viewpoint, the responsibility for dealing with the problem of noncompliance is not seen as belonging solely to the patient. The effective health care provider must share that responsibility by: (1) Assuring that the patient has the knowledge and skills necessary for compliant behavior; (2) maintaining an awareness of the "signs and symptoms" of noncompliance; and (3) helping the patient identify and remove obstacles to compliant behavior. When the disease is an infectious one, such as tuberculosis, the problem of noncompliance takes on an added dimension. Public health officials must understand and address the issue of compliance in order to assure that infectious cases of tuberculosis are brought under treatment and rendered noninfectious for the protection of others in the community.

Compliance is defined as the extent to which a person's health-related behaviors, i.e., taking medication, keeping appointments, etc., coincide with medical advice. Those who object to the term "compliance" because of its judgmental connotation, may wish to substitute the word "adherence" wherever "compliance" appears. Both terms are intended to be nonjudgmental; that is, there is no implication of blame.

Noncompliance is a protean feature of all self-administered therapeutic regimens, regardless of the medical condition(s) for which they are prescribed. Scheduled appointments that are initiated by health care providers are kept about 50 percent of the time. Compliance with medication prescribed over many weeks or months (as is the case with antituberculosis drugs) also averages about 50 percent.

It has been repeatedly confirmed that noncompliance is a major cause of relapse in tuberculosis. Reports submitted to the Division of Tuberculosis Control, Centers for Disease Control (CDC), by tuberculosis control programs throughout the United States indicate that about 20 percent of tuberculosis patients fail to complete therapy within a 24-month period. In some programs, the figure is as high as 50 percent.

Compliance with preventive therapy is also a problem. According to program reports submitted to CDC, 20 to 25 percent of the persons prescribed preventive therapy in the United States fail to complete treatment within 1 year. In an isoniazid (INH)-related hepatitis surveillance program conducted during the early 1970's, patients were prescribed the usual 12-month course of INH. About 64 percent of them picked up 3 consecutive monthly supplies of

INH, 41 percent picked up 6 consecutive monthly supplies, but only 22 percent picked up all 12 consecutive monthly supplies. Thus, data from several sources indicate that noncompliance is a major problem in tuberculosis control.

PREDICTING COMPLIANCE

Traditionally, health care providers have attempted to predict compliance based on subjective judgements of personality traits and behaviors. This approach is not very reliable. More objective tests, such as the Minnesota Multiphasic Personality Inventory, may be helpful, but are not very practical to apply in the clinic setting.

While it may be true that alcoholics are more likely to be noncompliant, our experience in using the brief Michigan Alcoholism Screening Test to predict noncompliance has been disappointing.

Recent research suggests that brief questionnaires based on the belief intention model may be useful for predicting compliance with antihypertension medication (See references 26 and 38). One study of a small group of adolescent girls indicated that a four-point self-assessment of past compliance with medications and a self-rating according to well-organized -- forgetful personality traits proved helpful in predicting compliance with contraceptive medications (See reference 36). Unfortunately, a questionnaire for tuberculosis patients has not been developed and tested.

MEASUREMENT OF COMPLIANCE

The value of estimates of an individual patient's level of compliance depend to some extent upon the specific behavior being measured, how it is measured, and how frequently it is measured. There are two basic methods of measuring compliance with medication taking: Direct and indirect.

Direct methods

Direct methods consist of the measurement of blood levels and/or urine levels of drugs and their metabolites. Blood levels can be determined by special arrangement in only a few selected laboratories (e.g., the National Jewish Center for Immunology and Respiratory Medicine or the Centers for Disease Control) and, hence, are not commonly used to measure compliance.

Several simple methods for testing urine for the presence of major antituberculosis drugs or their metabolites have been published (see Appendix) and a simple dipstick method for detecting INH metabolites in the urine is commercially available. Although some of these methods have been available for several years, they have been underutilized by most health care providers.

When testing urine or blood specimens, it is important to carry out the test at the right time. Information about the appropriate timing of tests is given in the Appendix.

Indirect methods

The following indirect methods of estimating compliance have been tried:

Response to therapy

The response of the patient to therapy can be ascertained by answering these questions: Did the sputum convert to negative? Did the chest film improve? Did the signs and symptoms disappear? This would appear to be a sensible, "bottom-line" approach to the detection of noncompliance, but using response to therapy as the sole method of assessing compliance is unsatisfactory for several reasons. First, several weeks or months may elapse between the initiation of therapy and the discovery that sputum conversion has not occurred or that the X-ray did not improve. In the meantime, transmission of infection may continue, drug-resistant organisms may emerge, or the patient may develop complications or die. Second, factors other than noncompliance, such as drug resistance, can lead to a poor therapeutic outcome. Third, a noncompliant patient may take enough drug(s) to become culture negative, but not enough to prevent treatment failure or relapse several weeks or months later. With respect to preventive therapy, this method is unsatisfactory for assessing compliance because "failure to respond," i.e., the development of tuberculosis, may not be detectable for decades.

Interview technique

A second indirect measure of compliance is the interview technique, i.e., the patient is asked, in a nonthreatening manner, whether he or she has missed taking any of the prescribed doses of medication. For example, the following question might be asked: "Many people have trouble remembering to take their medication every day; since your last visit, how many days have you forgotten to take yours?" Although many patients may deny noncompliant behavior, approximately one half of the noncompliant patients can be detected in this way.

Keeping appointments, refilling prescriptions, and pill counts

These are easy ways to detect noncompliance, but patients who keep appointments and obtain refills of prescriptions don't necessarily take their medication. Pill counts done during a home visit are of more value, but some patients may discard pills rather than swallow them.

Medication monitors

A fourth indirect method utilizes medication monitors, i.e., special packaging devices which can detect whether or not medication is removed at appropriate time intervals. However, their usefulness has not been adequately assessed in appropriately designed experiments. Furthermore, because medication monitors are not commercially available, this method cannot be routinely utilized at the present time.

Judgment of the provider

A final indirect method, the one most frequently utilized, is the health care provider's subjective assessment of compliance. Studies have shown, however, that physicians and other health care providers are very unreliable in assessing patient compliance.

DETERMINANTS OF COMPLIANCE

There are many factors which are known to affect compliance behavior:

Features of the referral process

The longer the interval between the time of referral and the time of appointment, the less likely it is that the patient will keep the appointment. Referral to see a specific provider, rather than referral to a clinic, enhances compliance, provided it does not increase waiting time.

Features of the clinical setting

Waiting time has an important effect on compliance rates. The longer the waiting time in a clinic, the higher the "no-show" rate on subsequent appointments. Although individual appointment times usually increase compliance, they may decrease compliance if the waiting time is prolonged. Other features of the clinical setting such as hours of clinic operation, distance from the patient's home, availability of snacks and coffee, cleanliness, etc., have not been well studied. It seems logical to assume, however, that a clean, easily accessible clinic with convenient hours of operation would be conducive to more compliant behavior. Research has shown that we are fonder of the people and things we experience while eating. Therefore, the provision of snacks and beverages to patients in the clinic has a rational basis.

Features of the regimen

Duration of treatment

The duration of treatment has an unequivocal effect on compliance. In general, adherence to treatment decreases with time. This is one consideration which has led to the study and recommended use of short-course chemotherapy regimens.

It is prudent not to tell the patient what the exact duration of treatment will be until drug susceptibility tests results and sputum conversion times are known since these factors will influence the decision. Tell the patient treatment might need to be as long as 18 months, but if he/she takes the medicine as prescribed and responds well, the duration of treatment might be much shorter.

Number of medications prescribed

Another factor of some importance is the number of medications prescribed--the larger the number, the lower the compliance rate. This poses a problem in tuberculosis control because appropriate treatment requires that two or more drugs be prescribed. The use of the INH-rifampin (RIF) combined capsule Rifamate^R, may improve compliance.

Frequency of dosing

Although not proven by controlled studies, it is probably important to simplify the regimen so that drugs are taken only once daily. In most tuberculosis treatment programs this is routine prescribing practice. The effect of prescribing self-administered therapy on a less-than-daily basis (e.g., twice-weekly) has not been studied in a controlled fashion, but Stead and Dutt have had good results with this approach in Arkansas.

Prescription labeling

Obviously ambiguous or unclear instructions on the prescription label may lead to poor compliance. Therefore, these instructions should be carefully, but concisely, worded.

Side effects

Although it seems logical that compliance might be adversely affected by drug side effects. Most studies have not shown this to be an important determinate for compliance. Patients should, however, be urged to report any suspected side effects to the health care provider.

Cost

The relationship between the cost of medications to the patient and compliance has not been carefully evaluated, but cost is probably a barrier. Today, most tuberculosis control programs offer drugs free of charge so that this potential barrier has been removed.

Safety-lock containers

Safety-lock ("child-proof") containers interfere with the compliance of some patients, particularly the elderly, arthritis sufferers, etc.

Parenteral medications

The use of parenteral medications, such as streptomycin (SM), often increase compliance, not only because some patient groups believe injectable drugs are better, but because of the supervision which is required (see below). Supervision of therapy obviously makes it easier to assess compliance.

Features of the patient's lifestyle

Compliance is more likely when medications are taken every day at approximately the same time. Therefore, anything that interfere's with the patient's ability to follow a regular daily schedule could constitute a barrier to compliance. Such barriers might include unpredictable work hours, frequent travel, unemployment, excessive use of drugs or alcohol, and lack of an income sufficient to meet basic needs. More research is needed in the effects of these factors on compliance.

Social support

There is evidence that patients who receive support from family and/or friends are more likely to comply. Those without such support may benefit from interactions with other patients (e.g., the so-called "breakfast clubs" in Fresno and Atlanta, soup kitchen in San Francisco, clubs in Baltimore), or from more prolonged intimate contacts with supportive and friendly clinic staff.

Health beliefs

During the 1950's, Dr. Godfrey Hochbaum and his associates in the U.S. Public Health Service, developed a theoretical framework for explaining the likelihood of an individual's undertaking a preventive health action, e.g., participating in a mass chest X-ray screening program to detect tuberculosis. This theory, usually called the Health Belief Model, states that an individual's adherence to a recommended health action is dependent upon his perception of: (1) His own susceptibility to the disease, (2) the seriousness of the disease; (3) the benefits of the health action; and (4) the barriers of taking the action. This theory has been the focus of several studies which suggest that, instead of preceding and determining compliant behavior, health beliefs develop along with compliance behavior as a result of the experience gained by patients during the early weeks or months of therapy. These findings suggest that the quality of the patient-provider interaction is important, especially during the early phase of therapy.

Locus of control

Research findings suggest that persons who feel they are in control of their own life are more likely to comply than persons who feel their life is controlled by external forces.

Features of the patient-health care provider interaction

Although the quality of this interaction is very important, it is difficult to objectively assess, describe, and teach. The desired outcome is obvious, however. Through this interaction, the patient should develop confidence in the health care provider and be motivated to comply.

Sir William Osler has been quoted as saying, "The art of patient care is in caring for the patient." This statement summarizes that attitude which best fosters a good patient relationship. Staff members who don't "care for their patients," but rather see patients as inferior, unworthy, ignorant, or a bother to take time with, cannot help but foster noncompliance. Despite what such staff may believe, they cannot avoid unconsciously communicating these feelings to their patients.

Marketing research has shown that people are more inclined to say yes to those they know and like. Furthermore, people tend to like those they perceive as being similar to them, i.e., of the same race/ethnic group, the same or a similar occupation, the same socioeconomic status, etc. Different patients may relate best to different persons on the staff and each staff member has the potential for playing an important role in enhancing the patient's compliance and chances for cure.

Demographic features of the patient

Patient characteristics such as age, sex, education, socioeconomic status, occupation, income, etc., have not consistently been shown to be associated with compliance. These factors do have an effect on access to health services, however.

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Features of the disease

Factors associated with the disease process, such as severity and number of symptoms are generally unimportant as determinants of compliance, although the degree of disability tends to influence compliance in a positive direction, i.e., the more disabled the patient is by the disease, the greater the likelihood of compliance.

STRATEGIES FOR IMPROVING COMPLIANCE

Effective strategies for improving the compliance of an individual patient are those that remove the specific barriers to compliance that are experienced by that individual. Thus, for the health care provider, possessing an understanding of the difficulties associated with behavior change and taking time to get to know the patient are essential.

Even though no perfect solution to the problem of noncompliance has been found, some proven strategies can be used to set the stage for enhanced compliance as well as to deal with problems when they do emerge (and in some situations, before problems emerge).

Patient education

In order to comply, the patient must first know what is expected of him or her. The health care provider must take the time to explain to the patient, in simple language, the specific compliance behaviors expected. The provider should also explain the basis for the diagnosis and the prognosis so that the patient understands the importance of complying with the medical advice. An interpreter will be required to communicate with those patients whose native language is not spoken by the health care provider. Whenever possible, clinics should be staffed with persons who can speak the language of their clients.

The amount of information which can be retained by a patient in one sitting is limited. Therefore, it is important for the provider to be organized, selective, and concise in talking to patients. Medical information first presented to the patient is more easily recalled than material presented later. It is best to outline the specific behaviors expected of the patient before explaining the basis for the diagnosis and the prognosis. The interaction with the patient should always be "two-way communication," i.e., the health care provider should elicit feedback and questions from the patient to assure that the message sent was received and understood. Because of the limitations in recall of oral communication, it is highly desirable to provide patients with written instructions. Written repetition of important material presented orally increases retention. It is important to gear the written material to the reading level of the intended audience. Merely providing patients with information, however, will not solve all compliance problems. Other strategies must be used to resolve specific compliance problems which arise.

Improving appointment-keeping

Various types of "reminders" are useful for improving appointment-keeping. A postal reminder card, mailed so that it arrives 1 or 2 days in advance of the scheduled appointment, is useful. However, telephone calls may be the best initial approach to solving the problem because they remove any doubt about whether the patient received the message or not. In addition, one can counsel patients over the telephone, and help them overcome scheduling and transportation problems and other obstacles to compliant behavior. If a clinic has a chronically low attendance rate, it is important to assess clinic operations, identify barriers to appointment-keeping, and make the necessary changes. Barriers to appointment-keeping behavior can sometimes be identified by contacting "no-shows" by telephone. Telephone or postcard reminders will not improve appointment-keeping if clinic visits are inconvenient or too time-consuming. Therefore, the provider must identify and solve these operational problems if appointment-keeping is to be improved.

Individuals who fail to keep an appointment should be contacted promptly by phone to schedule a new appointment. If the phone call fails to produce results, a home visit should be made immediately. Breaking of appointments should lead to a counseling session with the patient, designed to identify and solve problems which interfere with appointment-keeping. Repeated breaking of appointments should lead to a "case conference" attended by all members of the health care team (physicians, nurses, clerks, outreach workers, etc.) so that all pertinent information is considered and the entire staff can contribute to the solution to the problem.

Dealing with specific problems

For repeated or "chronic" compliance problems, instructions and simple reminders probably will produce only transient benefit. However, a combination of other strategies can be used to successfully identify and deal with specific problems.

Discuss the problem with the patient

Clearly state your concerns about noncompliance and its effect on therapeutic outcome to the patient. Listen to the patient's response and attempt to identify barriers to compliance which can be solved, e.g., correct misinformation, reduce side effects by "splitting" doses or giving drugs with meals, prescribe non-safety-lock containers, etc.

Problem solving should be a collaborative effort--not one in which the health care provider tells the patient how to solve the problem. No plan or intervention will be a success unless the patient helps solve the problem. The provider should facilitate the process.

If the patient comes from a cultural background which practices "nontraditional medicine," a thorough assessment of cultural barriers to the acceptance of traditional medical practices is necessary. Sometimes these patients have sought medical advice from nontraditional health care providers in their own culture. This information needs to be brought out and openly discussed.

Elicit social support

With the patient's permission, identify family members, friends, clubs, etc., who will support compliance behavior. Be sure, however, that the support person(s) is acceptable to the patient and is supportive of the provider's recommendations.

Tailor the regimen

Tailoring the regimen means simplifying and restructuring the regimen, within acceptable therapeutic limits, to coincide with the patient's lifestyle. Find a daily ritual that the patient finds pleasant and schedule medication taking just before that activity. If a reward can closely follow the taking of medication, it acts as a positive reenforcement for the behavior.

Behavior modification

Tailoring is a form of behavior modification. Other informal behavior modification methods can also be used. For example, simple verbal encouragement by members of the health care team, especially the physician, can be a very potent reenforcement when applied to ambulatory patients. For patients who lack motivation, behavioral strategies such as providing small gifts, snacks, coffee, monetary incentives, or awards for reaching therapeutic goals have often proven successful. Health departments in South Carolina and Alabama have successfully used incentives, such as food and babysitting services, to help noncompliant patients complete therapy.

The psychological principle of reciprocation suggests that doing favors for patients would enhance compliance. This principle says that we all try to repay a person who has done us a favor. By doing a patient a favor, we can legitmately ask them to do us a favor, namely take their medicine as prescribed. Such favors might include help in filling out forms, assistance in finding a place to live, providing a means of transportation to the clinic, etc.

Self-monitoring of pill consumption by checking off a calendar is sometimes useful for patients who truly forget to take their medicine.

For some patients, formalization of a written compliance agreement, "a health contract," between patient and provider works well. Instead of having the patient sign a statement someone else has prepared, ask the patient to dictate or write down in his/her own words a statement to the effect that he/she agrees to take the medicine as prescribed in return for good medical care given by the providers. This written commitment can often greatly enhance the likelihood of compliance. Furthermore, if, with the patient's permission, the clinic posts a list of patients who have made this written commitment, the likelihood of other patients' complying is likely to be enhanced.

Use extended supervision

Extended supervision, although more expensive than previously mentioned strategies, is a very effective strategy for improving compliance. It may entail: (1) Giving drugs under supervision; (2) making telephone calls and home visits; or (3) confining noncompliant patients to a hospital or other facility.

Many compliance problems can be obviated by the use of directly observed therapy. The effectiveness of this approach was demonstrated years ago, but directly observed therapy still has not been widely adopted in the United States. Such therapy can be administered daily or intermittently (e.g., twice-weekly). Intermittent regimens are generally less costly. Recommended intermittent supervised regimens include INH and RIF, INH and ethambutol (EMB), and INH and SM. All of these intermittent regimens require an initial period of daily therapy. The use of INH and RIF has the advantage of requiring a shorter total duration of therapy than the other two regimens.

Telephone calls and/or home visits to followup on broken appointments can be extremely valuable. The caller or visitor should ask about and observe for signs and symptoms indicative of treatment failure or drug toxicity. Any obstacles to compliant behavior should be discussed. During these visits, pill counts can be obtained, specimens collected for sputum smear and culture, and urine tested for the presence of drug(s) or drug metabolites. In some cases, direct administration of drugs in the home may be necessary to solve compliance problems.

As a general rule, individuals in our society have the right to refuse to follow health advice. Patients with tuberculosis, however, can sometimes be confined, by court order, to a hospital or other institution. The exercise of this "institutionalization option" (a very expensive approach to the problem) depends on the existence of appropriate laws and statutes, cooperative court and law enforcement officials, and the availability of institutional care. In many communities, one or more of these critical elements is missing. In all cases enforced institutionalization should be a solution of last resort. When enforced hospitalization is necessary, consideration should be given to the use of an "intensive" four-drug regimen (i.e., INH, RIF, SM, and pyrazinamide (PZA)) during the first 2 months of therapy. This approach will optimize the likelihood of cure, even if the patient absconds before receiving the full course of therapy.

A PRACTICAL GUIDE FOR DETECTING AND DEALING WITH NONCOMPLIANCE

Initial Compliance Assessment

Lay the groundwork for improved compliance at the time of the initial visit. Emphasize from the very first the need to take pills and continue taking them for the entire duration of prescribed therapy. Begin to collect information to assess the patient's likelihood of adhering voluntarily to the recommended therapy regimen.

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Within one week:

An assessment of potential noncompliance should be made through an interview with the patient and a home visit.

A staff member (e.g., a nurse or outreach worker) should be given responsibility for monitoring the progress of each new patient. When treatment is begun, the treatment team (this person plus the clinician, pharmacist, nursing supervisor, etc.) should discuss and agree upon a treatment and followup plan. In some cases, the probability of noncompliance will be judged high enough to justify immediately placing the patient on directly observed therapy (DOT). If the person responsible for monitoring the patient determines that the treatment plan is failing, the treatment team should develop a new plan.

Monthly Compliance Assessments

All patients should be carefully and continuously monitored for noncompliance during therapy. It is essential that a single individual on the provider "team" be assigned responsibility for ensuring that specific noncompliance assessment steps are taken throughout therapy. Suggested steps include:

Identifying missed appointments and contacting the patient immediately (this assumes that an effective system exists for keeping track of patients).

Asking patients, in a nonthreatening manner, whether or not they are taking their medication. Responsible relatives or friends may also need to be asked.

Identifying patients with a previous history of low compliance. Such patients are at high risk of repeating such behavior.

Asking patients to describe how and when they take their daily medication and comparing their response with the prescribed regimen.

Analyzing the appropriate body fluid (usually urine) for the drug or its metabolites. Simple tests for measuring levels of antituberculosis drugs and their metabolites in urine are given in the Appendix.

Conducting "surprise" and scheduled periodic home visits.

Measuring the remaining medication at each visit (pill count). Compare the amount of medication left in the bottle with the amount expected if the patients had followed the regimen exactly. Too much medication remaining indicates noncompliant behavior, but the removal of medication from the bottle does not necessarily mean compliance has been good. This method is most useful during unscheduled home visits.

Other Methods for Enhancing Voluntary Compliance

Depending on resources and the patients reliability, one or more of the following compliance improving strategies should be applied:

Pay More Attention to the Patient

Patients who miss appointments should be contacted immediately by phone or home visit. Talk to the patient about the problem. Help the patient identify and solve problems that are interfering with compliance. Communications with the patient should be in the language which the patient understands. Translator services should be available if needed.

Preappointment Reminders

Telephone patients at least 48 hours prior to their next scheduled clinic appointment to remind them of their appointment. If this is not possible, mail them a reminder.

Restructure the Regimen

Tailor the taking of medications to coincide with the performance of daily habits or rituals, e.g., having morning coffee. Simplify the treatment as much as possible. Consider using the combined INH-RIF capsule.

Elicit the Support of Family Members and Friends

Relatives or friends whom the patient respects can help with compliance problems. Avoid involving persons whose influence will be detrimental, however.

Behavioral Strategies

Feedback information to patients about their urine test results and their therapeutic responses. Positive reenforcement of compliance in the form of praise and encouragement can be quite powerful in motivating further compliant behavior. Consider giving special incentives such as small gifts or letters of praise and commendation for achievement of treatment goals. Consider a formal written compliance agreement.

Confinement of Tuberculosis Patients

Public health officials should be provided with the legal means to confine at public expense noncompliant, sputum positive tuberculosis patients who pose an infectious threat to the general community. Such confinement should be maintained until treatment is complete.

Patients with sputum positive pulmonary tuberculosis which is so drug resistant as to be refractory to treatment are potentially infectious to the general community. If cooperative, these individuals may be confined at home with close supervision by health department personnel. If uncooperative, permanent confinement should be imposed at public expense.

Final Note

When asked for a recommendation for improving patient compliance with TB therapy, an experienced public health nurse from Arkansas said recently, "What we do is 'whatever it takes!" These words seem to summarize all the above recommendations and to embody a philosophy which no longer accepts noncompliance as inevitable and tolerable. Identifying and doing "whatever it takes" to assure completion of adequate therapy is a difficult challenge, but one that must be successfully met, if this curable and preventable disease is to be conquered.

DHHS:PHS:CDC:CPS:DTBC:2/86

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APPENDIX

Tests for the Detection of Antituberculosis Drugs or Their Metabolites in the Urine

Several simple, reliable, and relatively inexpensive tests for demonstrating the presence of antituberculosis drugs or their metabolites in the urine have been developed. Methods for performing a variety of tests were published in a World Health Organization technical bulletin in 1969 by Eidus and Ling (1). More recently, Burkhardt and Nel (2), and Kirsten, Armstrong, and Gatner (3) published the following methods and results of testing urine for the presence of N-acetyl INH, PZA and its metabolites, RIF and desacetyl-RIF, and EMB.

Color Test for N-Acetyl INH in Urine (1,2)

N-acetyl INH is the main metabolite of INH. It is present in the urine in larger quantities and for longer periods of time than any other INH metabolite.

The test is done in a white porcelain spot plate with hemispherical depressions which enables easy reading of results and examination of several specimens at the same time.

Reagents. Two solutions are made up and are stored separately: (1) A 10% solution of potassium cyanide (KCN), reagent grade, in distilled water; and (2) a 10% solution of chloramine-T in distilled water. The reagents may be stored in the refrigerator at 4°C in amber bottles for 1 week.

Procedure. In each plate depression the following are added in strict sequence by pasteur pipette and without shaking or stirring: (1) Four drops urine, (2) four drops 10% KCN solution, and (3) nine drops 10% chloramine-T solution. It is important that the specified number of drops be used, that the sequence is strictly adhered to, and that there is no delay between additions of each successive reagent. The method is so quick and easy that 300 urine specimens can be collected and processed in a day. Known INH-positive and -negative control urines are included in each test series to monitor the quality of the reagents.

A positive reaction is indicated by a cherry-red color of varying intensity, which develops within 1 minute. A pink color indicates that only traces of N-acetyl INH are present, and negative urine remains yellow.

The estimated cost of the test is 14 cents per 100 urine tests (2).

Burkhardt and Nel (2) reported that, after a dosage of 400 mg INH, the N-acetyl-INH metabolite could be detected after 2 hours in 96% of the urine specimens tested, after 4-6 hours in 100%, and after 8 hours in 80%. After 24 hours, none of the urine specimens were positive. Ellard and Greenfield (4) have reported a slightly more elaborate, but much more sensitive, test for INH metabolites. This procedure may eventually become the preferred test as experience with it accumulates.

A reagent-impregnated paper test strip commercially available from Difco Laboratories, is also available (5), and may be preferred by those who do these tests infrequently.

Color Test for RIF and Desacetyl-RIF (2)

RIF and its metabolite, desacetyl-RIF, are detected in urine by the following method:

Procedure. A 10 ml urine sample is pipetted into a test tube and 2 ml n-butanol (reagent grade) is added. The liquids are mixed by inverting the tube gently twice. The tube is allowed to stand for at least 30 seconds to let the butanol separate again.

In positive urine a salmon-pink to cherry-red color appears in the upper butanol layer. A light orange color indicates the presence of only a trace of RIF and desacetyl-RIF. A false-positive result can occur if the urine sample contains an excess of urobilinogen.

The estimated cost is 68 cents per 100 urine tests (2).

Burkhardt and Nel (2) reported that 2 hours after 17 patients had ingested 450 mg of RIF, all urine specimens were positive, and they remained positive for 6-8 hours after ingestion. After a 24-hour period, RIF or its metabolites could be detected in only 25 percent of samples.

Color Test for EMB (3)

A 1 ml urine sample is placed in a 13 mm x 90 mm test tube. An equal volume of bromothymol blue solution (0.04 g bromothymol blue dissolved in 20 ml absolute alcohol; 80 ml M/15 phosphate buffer, pH 7) is added, mixed, and 3 ml of benzene are added. The test tube is sealed and the contents mixed by inversion. A distinct yellow coloration in the benzene layer denotes the presence of EMB in the urine. A standard 50 ug/ml solution of ethambutol in water provides a useful reference.

Kirsten, Armstrong, and Gatner (3) reported that 12 volunteers ingested EMB 25 mg/kg, and urine samples were taken immediately and at 2, 4, 6, 8, 10, 12, 24, and 48 hours after ingestion of the drug. Using the methods described above, no EMB was detected at 2 hours. Peak EMB concentrations were obtained at 4 hours, and in some cases, traces were still detectable 48 hours after ingestion.

In using this test, the following points must be noted: (1) Albumin rich urine may occasionally give rise to false-negative results; (2) the presence of rifampicin in the urine may obscure the test results; and (3) false-positive results may be encountered in patients who are being treated with phenothiazines.

Color Test for PZA and its Metabolites (2)

The major metabolites of PZA measured are pyrazinoic and 5-hydroxpyrazionoic acid.

Reagents. Two solutions are made up and are stored separately: (1) A 2% aqueous solution of sodium nitroprusside, and (2) a 2N solution of sodium hydroxide (NaOH 8.0 g/dl distilled water). The sodium nitroprusside reagent is stored in an amber bottle and will keep for 2 weeks in the refrigerator at 4°C.

Procedure. Before performing the urine tests, equal small aliquots (e.g., 2 ml) of each reagent are freshly mixed in a test tube, since the resultant final solution is only stable for 1 hour, after which it must be discarded.

In a white porcelain spot plate, the following are added by pasteur pipette: (1) 3 drops urine and (2) 1 drop constituted reagent. The plate is gently shaken. In the presence of PZA the bright yellow color of the solution changes to orange within 3 minutes. Known PZA-positive and -negative control urine is included in each test series to monitor the quality of the reagents.

The estimated cost of the test is approximately 1 cent per 100 urine tests (2).

Burkhardt and Nel (2) reported that after the intake of 2 g PZA, all the urine specimens tested were positive for a period of 2-8 hours; in 68% of the samples the overnight urine specimens were still positive.

Simultaneous administration of RIF and PZA (with a resultant reddish coloration of the urine due to RIF) did not interfere with the interpretation of a positive PZA reading. It is not always easy to distinguish, however, between the canary-yellow color of the negative control urine and the brick-orange of a weekly positive specimen.

Tests for Other Drugs

Methods for testing urine specimens for para-aminosalicylic acid, cycloserine, and ethionamide have been published (1) but will not be presented here.

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FACTORS RELATED TO COMPLIANCE WITH THERAPY

Referral process

Clinical setting

Duration of treatment

Number of medications

Frequency of dosing

Prescription labeling

Side effects

Cost

Safety-lock containers

Parenteral medications

Lifestyle

Social support

Health beliefs

Locus of control

Patient-health care provider interaction

STRATEGIES FOR IMPROVING COMPLIANCE

Educate the patient; explain expected compliance behaviors

Improve appointment-keeping

Confront the patient

Elicit social support

Tailor the regimen

Use behavior modification

Use extended supervision

COMPLIANCE

HANDOUT

Compliance Case Study

COMPLIANCE CASE STUDY

LUTHER

Luther is a 54 year-old single unemployed male. He is a veteran, receives a small disability pension, and sometimes picks up odd jobs in the warehouses and diners on River Front Street. He lives in a single room occupancy hotel.

Sixteen weeks ago he was brought by the police to the emergency room of City General Hospital for treatment of stab wounds to the right arm and cuts on the neck and face resulting from a fight outside a tavern on the waterfront. He was admitted for treatment and observation. Upon admission he was intoxicated, appeared poorly nourished and under weight, and had a productive cough. The chest radiograph revealed an infiltrate in the left upper lobe. Sputum smears were positive for AFB. He was started on isoniazid (INH) 300 mg., rifampin (RIF) 600 mg., and pyrazinamide (PZA) 2 g. daily. He remained hospitalized for five days. On the day of discharge, the infection control nurse telephoned a report to the health department and instructed him to go to the tuberculosis clinic at the health department the next morning for evaluation and a supply of medicine. He failed to keep the appointment. The next week an outreach worker was assigned to locate Luther and persuade him to come to the clinic. After considerable time and effort, the outreach worker found him lying on a park bench near the hotel where he lives. Luther agreed to ride to the clinic, a distance of 6 miles from his hotel, with the outreach worker.

The clinician had left orders for the staff to administer a tuberculin skin test, obtain a chest x-ray, collect sputum specimens, and issue a 30-day supply of drugs. An hour and a half later, these services were performed, and a clinic nurse did a five-minute interview which resulted in her obtaining the names of two contacts. He was instructed to report back to the clinic at 8:00 a.m. in two days to have the skin test read and to return in 30 days for more drugs. The outreach worker had left the clinic to work in the field and was not expected back until the next morning. Luther walked to his hotel. The nurse noted in the record that the patient did not seem to be concerned about having tuberculosis and that he had been warned not to drink while he was taking tuberculosis drugs.

Luther failed to return to have his skin test read. The outreach worker brought him to the clinic the next day, and the skin test was read as positive at 15 mm. The nurse told him the test was positive, to continue the medicine, and to come back as previously instructed for his next supply of drugs.

The State laboratory report indicated that the sputum culture was positive for M. tuberculosis.

Luther did not return to the clinic to pick up his second month's supply of drugs. Seven days later, the outreach worker was asked to give him another appointment. An appointment card was left under Luther's door, but he did not come in on the scheduled day. A week later, Luther came to the clinic at 4:30 p.m. asking to see a doctor. He was told the doctor was not in, but was given his drugs. He did not return as instructed to pick up his third month's supply of medicine.

DHHS:PHS:CDC:CPS:DTBC:9/87

Part II: Interviewing

PART II: INTERVIEWING

CVERVIEW OF PART II: INTERVIEWING

"Part II, Interviewing" is designed to build interviewing skills. Participants will learn how to plan an interview and construct an outline that contains open-ended questions. They will observe a demonstration interview, become familiar with rating an interview using a checklist, and learn how to provide feedback about the interviewer's strengths and weaknesses. Participants will do practice interviews in small groups. Each participant will then conduct a simulated interview which will be videotaped in class. The videotaped interviews will be played back, rated, and critiqued. This is an action session in which all persons enrolled in the course are expected to take part. Skill-building occurs throughout the session.

Planning the Interview

PART II: INTERVIEWING

PLANNING AND STRUCTURING THE INTERVIEW

PLANNING AND STRUCTURING THE TUBERCULOSIS INTERVIEW

TIME: 75 MINUTES

MATERIALS/EQUIPMENT

Flip chart

Handouts: Interview Case Study: Jake
Expanded Tuberculosis Interview Outline

REQUIRED READING FOR PARTICIPANTS

Participant Guide material for this session.

OBJECTIVE

Participants will be able to prepare an interview outline applying the planning steps and the master parts of an interview.

INSTRUCTOR NOTES | **LESSON PLAN**

INTRODUCTION
Time: ______________

We are now entering Part II of this course which is devoted to interviewing.

In our earlier segment on interviewing in Part I, we established that a tuberculosis interview is an individualized exchange of information between a health care provider and a client.

The interview, then, is a way of communicating with our clients. It is a mechanism through which we obtain information, provide information, give help and counsel, and teach. Two of the most important objectives (there can be others) of an interview with a patient or suspect are:

FLIP CHART

Write the objectives on the chart in advance.

1. To educate the patient about tuberculosis and promote compliance with the recommended treatment and followup plan.
2. To obtain information, including names and addresses, needed to structure the contact investigation.

As we learned earlier, the success of tuberculosis control activities is directly related to the health care provider's establishing and maintaining a positive relationship with TB clients. Communication is the foundation of the relationship. It follows, then, that we must communicate effectively with clients. One way we communicate with clients is the interview. Each of us has the responsibility to make every interview we conduct as productive as we can. When we fail in an interview session, both the patient and the program lose.

What can we do to make our interviews productive for the patient and the program? Your Guide gives you some clues that will help make your interviews successful.

INSTRUCTOR NOTES | LESSON PLAN

Let's review these clues. Remember them when you interview patients, and you will be more successful as an interviewer.

First clue. Arrange for privacy. Conduct the interview in a setting in which the patient knows that the information that is being shared is just between him/her and you. Most people feel freer to talk about personal matters, including their health status, when they know others are not listening.

Second clue. Create an atmosphere free of distractions and interruptions. This enables the patient to concentrate and shows that you are truly listening.

Third clue. Establish rapport with the patient. People communicate more freely when they like and feel comfortable with the other person.

Fourth clue. Listen attentively to the patient. We have talked a lot about listening. Remember that the greatest responsibility in the communication process belongs to the listener.

Fifth clue. Be objective and unemotional. We are professionals. Clients expect us to relate to them in a professional manner.

We can be sure we are incorporating these clues into our interviews if we consistently apply the principles of communication we covered earlier in the course to each interview.

CALL ON PARTICIPANT(S)

What do you think about these clues? Who can relate one or more of them to a personal interview experience?

Allow one or two participants to respond briefly. If necessary, stimulate the discussion with the examples that are provided.

How about conducting the interview in a private office or other clinic room vs. the waiting room? In the car vs. the patient's living room where other family members and friends are present?

Have you thought about asking the secretary to take telephone messages instead of routing calls to you during the interview?

And what about looking at the patient, giving feedback, and asking for clarification vs. leaning back in the chair and gazing out the window while the patient is talking?

These examples stress the value of remembering and using these clues in the interview situation.

Let's make a quick point about our attitude toward the patient. Two attitudes health care providers can easily develop and nurture in interactions with clients are:

1. The patient is an adversary in the interaction process.

2. I have to be a 'friend' to all my patients.

In interview situations, as well as other interactions with patients, we need to strive for a balanced combination of these two attitudes. It is important for us to motivate patients to comply with treatment and followup recommendations and to identify contacts for examination, but not to the point of alienating the patient. It is equally important to develop and maintain a good relationship with the patient in order to promote desired behaviors, but not at the expense of appropriate confrontation on problems and conflicts in information that surface during the interaction.

PLANNING THE INTERVIEW
Time: ____________

Planning is very important to the outcome of an interview. When we plan for an interview, we can prevent many problems and we are better prepared to deal with any that do arise during the interaction with the patient. One of the interviewer's principal responsibilities is to ensure that good communication is established and maintained with the patient so that the objectives of the interview will be achieved. Planning the interview is an essential component of the interviewer's responsibilities.

Let's review the planning steps that are listed in your Guide. You should take these steps before inviting the patient into the interview situation.

Determine the objective(s) of the interview

Go into every interview with a firm knowledge of what you want to accomplish. Your objective may be to give information to the patient. If so, know precisely what you want the patient to understand. Your objective may be to gain information from the patient. Know exactly what information you need to get from the patient. The best interviews involve two way exchanges, i.e., giving and receiving information. For most interviews, the objectives are to give and receive information.

Analyze the interview situation

Be prepared to tailor the interview to meet the special needs of individual patients. Know in advance what those needs are, if possible, and be prepared to adapt to any other factors which the patient might introduce. For example, does the patient speak a language other than English which would require the interview to be conducted in another language or an interpreter to be present? Is the patient from a cultural background that ascribes different meanings to gestures and other body language we might use in the interview? Will the patient have time for the interview when you plan to do it, or must the interview be abbreviated or rescheduled?

Decide the strategy for the interview

Determine up front that you will be in charge of the interview. It is your job to guide the flow of information and attain the objectives. Jot down on paper, or use a standard interview outline, to be sure you cover everything.

Anticipate and prepare to deal with resistance

Decide how you will handle the patient's resistance if it develops during the interview. Resistance can usually be avoided or minimized if you pay attention to tactfully opening the interview session and establishing rapport. Be prepared to use problem solving techniques, including confrontation.

Arrange the timing of the interview

Schedule the interview for a time when you can be reasonably sure of having the patient's complete attention and when you can devote complete attention to the patient and the interview.

By taking these five planning steps, you can prevent many problems and you will be better prepared to deal with any that arise during the interview. Remember that one of your principle responsibilities is to establish and maintain effective communication with the client in order to successfully impart and obtain information. Planning the interview is an essential part of your responsibilities as an interviewer.

Let's look now at the structure of an interview. There are four main parts to an interview. These are discussed in detail in your Guide.

The four main parts of an interview are:

The introduction;

The body;

The conclusion; and

The followup.

Introduction

The introduction is the foundation for the rest of the interview. It is that part of the interview in which we establish a "working" relationship with the patient and define the purpose of the interview for the patient. This is a crucial element, because failure in constructing the foundation invariably results in weaknesses throughout the interaction. The interviewer must develop rapport with the patient and gain his/her confidence. The introduction should be a conversation that arouses the patient's interest and gets attention. Some "small talk" (e.g., about the patient's nice appearance, last night's basketball game, the weather, etc.) is appropriate as long as it is genuine and not condescending. We must demonstrate that we are warm and caring. We must show sincere interest in the patient. It is also important to convey that we have the skills to help the patient.

Body

After we establish rapport with the patient, we then advance to the body of the interview. The body is the part in which the interviewer gives information to and obtains information from the patient. Several important information exchanges take place. The interviewer:

Identifies and resolves the patient's concerns;

Obtains information needed to structure contact investigation activities;

Explains the disease and mode of transmission;

Reinforces therapy recommendations;

Stimulates the patient to comply with treatment and followup recommendations;

Answers questions; and

Elicits names and locating information of contacts.

In the body of the interview, we actually implement the strategy developed for the interview during the planning phase. The value of having a notes or an outline about what should be communicated with the patient becomes vividly clear during this part of the interview. Don't make the mistake, however, of rigidly sticking to the plan if you feel that to do so will do more harm than good. We must always be flexible enough to depart from a fixed interview outline if it does not seem appropriate with an individual patient.

In most interviews, the chief job of the interviewer is to ask the patient questions. Questions should be asked one at a time. Wait for an answer. If the patient does not respond immediately, resist the urge to move to another question right away. Rephrase the question, if necessary. Sometimes it may be appropriate to move on to the next question before a prior question is answered, but the patient should clearly understand that the unanswered question will be presented again later in the interview session. It is best to start with general questions and gradually move to those that are more specific and require more thought by the patient in order to respond. Use open-ended questions.

Conclusion

Terminate the interview only when the objectives have been met. Avoid stopping the interview earlier unless there is reasonable evidence to believe that further communication with the patient at that particular time will not be productive. If you have an agreement with the patient to end the interview at a specified time, that agreement should be honored even if the objectives have not been met. In these situations, you absolutely must arrange a date and time with the patient to continue the interview. When concluding the interview, do the following:

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Summarize the main points of the interview;

Invite the patient to ask questions and answer them;

Establish a date and time for the next interview (clinic visit, home visit, etc.); and

Express appreciation for the interview and bid the patient farewell.

Followup

Most interviews need to be followed by a letter, return visit, home visit, or reinterview. This activity is just as important to the success of the interview as the introduction, body, and conclusion. Followup is especially important in monitoring the patient's compliance with therapy recommendations. It is essential if information about contacts turns out to be inaccurate or incomplete.

We are now going to put into practice the concepts we have learned in this session. Earlier in the course I gave you a Brief Tuberculosis Interview Outline. Using a case study (Jake), I'm going to ask you to develop a more comprehensive interview outline which you would use in an actual interview with the patient.

HANDOUT

Interview Case Study: Jake

GROUP EXERCISE

Time: ______________

Break the class into groups of four or five persons. Give each person a copy of the Interview Case Study. Instruct the groups to design an interview outline which incorporates the interview objectives, introduction, body, conclusion, and proposed followup. Have them include in the outline the questions they plan to ask. The outline should be their plan for giving information to and obtaining information from Jake.

Allow the groups about 20 minutes to work. Reserve 10-15 minutes for at least one group to present the outline to the class. Ask one member of the group to be the spokesperson.

When the group excercise is completed, give everyone a copy of the Expanded Tuberculosis Interview Outline.

HANDOUT

Expanded Tuberculosis Interview Outline

Distribute handout.

INSTRUCTOR NOTES	LESSON PLAN
HOMEWORK FOR TOMORROW	Your homework assignment tonight is to study the Expanded Tuberculosis Interview Outline and the Interview Case Study which you received in class today. Review your notes and Participant Guide material covered in class today. Tomorrow we are going to put into practice all the concepts and principles we learned today. Each of you will have an opportunity to interview Jake and receive feedback from the other members of the class. We will videotape the interviews and then play them back so you can also critique your own interview style and technique. Before you interview Jake tomorrow, we will do a demonstration interview for you, and you will have the opportunity to practice in small groups.
Call for questions. Offer your time after class for individual consultation and assistance.	

PLANNING AND STRUCTURING THE INTERVIEW

HANDOUTS

Interview Case Study: Jake

Expanded Tuberculosis Interview Outline

INTERVIEW CASE STUDY

JAKE

Jake Buckner is a 37 year old male who is the office manager at Minico, Inc. Four weeks ago, he visited the company nurse complaining of fever, loss of appetite, and a cough of 2 weeks duration. The nurse suggested that he make an appointment to see his private physician. One week later, Jake was evaluated by his physician who diagnosed him with acute bronchial infection and prescribed an antibiotic and decongestant cough formula. He continued to work although his symptoms persisted, but he took 2 days of sick leave and left work early twice because of fatigue. Last Monday Jake returned to his physician. He was still coughing and had lost a total of 9 pounds. The physician referred him to a radiologist for a chest x-ray examination. The chest x-ray, which was read on the same day, showed a subapical infiltrate in the left lung. Jake's physician called the city health department and made arrangements for him to be seen on Tuesday for an evaluation. At the health department, Jake was given a Mantoux tuberculin skin test and sputum specimens were obtained. The clinician, after reviewing Jake's history, clinical findings, and chest x-ray, prescribed isoniazid (INH) 300 mg., rifampin (RIF) 600 mg., and pyrazinamide (PZA) 2 g. daily. He instructed Jake to return to the clinic on Thursday to have his skin test read and to get his laboratory report.

Thursday: Jake returned to the clinic. The nurse read his tuberculin skin test as 15 millimeters of induration. The laboratory report indicated numerous acid-fast bacilli seen on smear, culture pending. The clinician made a presumptive diagnosis of pulmonary tuberculosis and instructed Jake to continue the medicines that were prescribed the day before yesterday. The clinician sent Jake with his record to your office for an interview.

EXPANDED TUBERCULOSIS INTERVIEW OUTLINE

I. Introduction

A. Introduce yourself to the patient. Begin building rapport.

B. Explain your role in the tuberculosis control program.

C. Focus the patient's attention on tuberculosis. One way to do this is by saying:

"Dr. ___________ tells me that you have tuberculosis" or "I see in your medical record that Dr. __________has diagnosed you as having tuberculosis. The doctor has asked me to talk with you, as I do with all tuberculosis patients."

D. Explain the purpose of the interview:

1. To help the patient actively participate in the treatment and management of the disease so that good health is restored.
2. To identify others with infection and disease to stop the spread of tuberculosis.

Make a transition from the Introduction to the Body with a "bridge" statement/question. Examples to choose from are:

"I realize that you may already know a great deal about tuberculosis; however, today I want to go over the most important points again about this disease."

"Tell me what you have heard or read about tuberculosis. There is a lot of information about this disease that you have heard that may not really apply to your case."

"I know that you have received a lot of information about tuberculosis. What questions do you have"?

"Tell me what is the most confusing (hard, difficult to understand, hard to do, hard to remember, etc.) for you about tuberculosis."

"What will be the hardest thing for you to do that the doctor has recommended?"

"Some people find that tuberculosis is hard to deal with. What types of trouble do you expect you'll have with this disease?"

"What would help you take your tuberculosis medicine on a regular basis?"

"Why do you think some people have trouble taking their tuberculosis medicine? What would influence you the most to take your medicine?"

II. Body

A. Patient Assessment

Continue building rapport and begin problem solving.

1. Physical observation

   a. Make note of any physical signs, such as alcoholism, drug abuse, nutritional status, lifestyle, and other illnesses, that may be indicative of the patient's cooperation in the interview and have a negative effect on compliance.

   b. Observe the patient's body language throughout the interview.

2. Patient concerns

   a. Identify any patient concerns (treatment, cure, clinic appointments, protection of family members, clinic experience, etc.) Resolve those concerns now even if it means departing from the planned format of the interview.

   b. Assess the patient's intellectual level, attitudes, and needs. Begin planning what and how to tell the patient about tuberculosis, treatment, contact investigation, etc.

   c. Assess the patient's communication skills. Begin to anticipate problems. Develop potential strategies for subsequent sections of the interview.

3. Personal information

Explain why it is important for you to have accurate personal as well as medical information in order to help.

Determine the extent of rapport developed in the interview to this point. Observe the patient and assess responses.

a. What is your full name?

b. What other name(s) do you go by? (What do your friends call you? What is your nickname?)

c. May I call you ___________?

d. How old are you? (What is your age? What is your birthday?)

e. What is your marital status? (Married, single, widowed, or divorced?)

f. Where do you live now? (Verify with drivers license, ID card, etc.)

g. How long have you lived at _______________?

h. How do you (I) get to your house/apartment? (What are the directions to your house/apartment?)

i. Where did you live before you moved to the house/apartment you live in now?

j. What is your telephone number? (Privately verify with the telephone directory before the patient leaves.)

k. Whom may I contact if I (we) need to reach you when you are not at home? (Name, address, telephone number.)

l. Who is your next of kin? (Name, relationship, address, telephone number.)

m. Where do you work (go to school)?

n. What hours do you work (go to school?)

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4. Medical history and disease comprehension

   a. What do you know about tuberculosis? (Do not ask this question, if you asked it in the "bridge."

      Reinforce what the patient knows about the disease and correct any misconceptions.

      Explain the natural course of the disease and mode of transmission using language the patient can understand. Focus on the shared air principle. Avoid giving a medical lecture.

   b. When were you last examined (tested) for tuberculosis infection and disease?

   c. What were the examination results?

   d. When did you start coughing?

   e. How frequently (how much) do you cough?

   f. How much sputum do you bring up when you cough?

   e. When did you first notice being hoarse or having laryngitis?

   f. When did your chills and fever begin?

   g. How much weight have you lost?

   h. When did you notice you were losing weight?

   i. Who has (or has had) tuberculosis that you think you might have been exposed to?

      Discuss the patient's diagnosis and treatment recommendations (current status):

      1. Tuberculin test results
      2. X-ray/clinical findings
      3. Smear and culture results
      5. Site of disease
      5. Chemotherapy recommendations

B. Transmission Interruption Behaviors

1. Take medication

   a. Explain that the drugs kill tubercle bacilli. Reinforce the personal and public health benefits of taking the medicine.

   b. Identify and explain each prescribed drug. Show the bottles to the patient. Go over the written instructions on the labels.

   c. Discuss the dosage of each drug.

   d. Establish a specific schedule for the patient to take the drugs.

   e. Discuss potential side effects.

   f. Emphasize the need to take the drugs at the times and for the length of time prescribed.

   g. Identify and discuss potential compliance problems. Incorporate strategies to enhance compliance.

2. Cover cough

   a. Instruct the patient about using a tissue to cover mouth and nose when coughing. Explain proper disposal technique. Emphasize that taking the drugs as prescribed and covering the cough are the most important measures the patient can take to protect others.

   b. Discuss venting the room air to the outside as another technique for protecting others.

3. Return for prescription refills, followup examinations, and medical evaluations

   a. Explain why the drugs are issued in 30-day supplies. Re-emphasize the importance of continuity of therapy.

   b. Explain the need for sputum and chest x-ray examinations. Discuss the approximate schedule. Show containers to the patient. Instruct the patient on collecting and submitting sputum specimens to the laboratory. Provide containers.

   c. Discuss schedule of physician and/or nurse monitoring of the patient's progress during therapy.

   d. Establish (negotiate) date and time for the next clinic visit.

   e. Identify and discuss potential compliance problems.

C. Contact Investigation

1. Introduction of the process

   a. Review the patient's comprehension of the disease and the mode of transmission. Focus on the shared air principle.

   b. Discuss the importance of examinations for persons who have shared air with the patient and explain the type of examination(s) they will receive.

   c. Assess the patient's response to the interview thus far and determine if he/she has concerns about contact investigation activities.

2. Contact identification

   a. Household environment contacts

      1. How is your house/apartment heated in the cold weather months?

      2. How do you cool your house/apartment in the hot weather months?

      3. How many people live with you now in your house/apartment?

      4. How many other people have lived with you in your house/apartment during the past six months?

      5. During the past three months, how many overnight guests have you had at your house/apartment?

      6. How many daytime or evening visitors, e.g., neighbors, friends, and relatives, have been to your house/apartment in the past two or three months?

      7. When was the last time you were out of town?

      8. On the nights when you don't go to your house/apartment to sleep, where do you spend the night?

      9. How many bedrooms are in your house/apartment?

      10. How many other people sleep in the same room you sleep in?

   For homeless and transient patients, modify the above questions to obtain information about shelters, missions, jails, migrant camps, etc.

Use open-ended questions and ask the patient for the following information about each person now living in the household:

Name and nickname

Relationship to patient

Age

Sex

Physical description

Employer or school

Other locating information.

Use open-ended questions and ask the patient for the following information about other people who have lived in the household during the recent past, overnight guests, and daytime visitors:

Name and nickname

Address

Directions to residence

Telephone number (verify with telephone directory)

Who the person lives with

Relationship to patient (relative, friend, neighbor, etc.)

Age

Sex

Physical description

Employer or school

Other identifying and locating information

Analyze all the responses for conflicts in information. Identify problems and confront inconsistencies. Evaluate problems and select appropriate solutions along the way.

b. Work/school environment contacts

1. How long have you worked (gone to school) at ______________________?
2. What kind of work do you do (What grade are you in) at ______________________?
3. Where do you do your work? Inside or outside?
4. (If inside) What kind of space do you work in? Enclosed or open? (Ask the patient to describe the area.)
5. How many people work in the same work space with you?
6. In addition to the employees in your work space, how many other employees do you spend time with at work?
7. What type of heating and cooling systems does your place of employment (school) have?
8. What kind of lunch and break areas does your place of employment (school) have?
9. Where do you eat lunch?
10. How (transportation method) do you get to and from work (school)?

For unemployed (not in school) patients, modify the questions to obtain information about the places (other than the house/apartment) where the patient spends time.

If the patient works in a closed indoor setting, or if the probability exists that any coworkers have been exposed, use open-ended questions and ask the patient for the following information about work associates (classmates, teachers):

Name and nickname

Address

Directions to residence

Telephone number (verify with telephone directory)

Who the person lives with

Age

Race

Sex

Physical description

Other identifying and locating information

Analyze all the responses for conflicts in information. Identify problems and confront inconsistencies. Evaluate problems and select appropriate solutions along the way.

c. Leisure Environment Contacts

1. How do you spend your spare (leisure) time?

2. Which clubs, bars, and meeting places do you go to most frequently?

3. How much time do you spend there?

4. How many people do you regularly see when you are at your club (bar, meeting place)?

5. What church do you attend?

6. Do you sing in the church choir or other musical group?

f. How many "best friends" do you have?

g. How many steady sex partners do you have?

h. Which places have you traveled to during the past two or three months?

i. When was the last time you were out of town overnight?

j. How long were you away on these trips?

k. Where did you stay?

If information about leisure activities suggests that exposure of others is a probability, use open-ended questions and ask the patient for the following information about persons with whom he/she shares leisure time:

Name and nickname

Address

Directions to address

Telephone number (verify with telephone directory)

Who the person lives with

Age

Race

Sex

Physical description

Other identifying and locating information

Sex partners including extramarital partners

Analyze all the responses for conflicts in information. Identify problems and confront inconsistencies. Evaluate problems and select appropriate solutions along the way.

__NOTE__: Your sensitivity to the patient's answers to the preceding questions is extremely important. Most patients will respond positively and openly; however, be prepared to begin problem solving and provide a reassuring answer if the patient asks, "Why do you need that information?" This type of response, along with nonverbal signs of discomfort, are indicators of patient concerns. Assess the degree of rapport that has been established and address any previously unexpressed patient concerns; resolve problems. Restate the purpose of the interview. Continue problem solving to deal with concerns which are commanding the patient's attention before proceeding from one segment of the interview to the next.

3. Methods of referral

a. Inform the patient that contact investigation and referrals will be carried out immediately.

b. Determine the patient's capability to participate in contact referrals.

c. Inform the patient that it is sometimes necessary for site visits to be made to the home, workplace, school, leisure establishments, etc. to assess the shared air environment in order to accurately structure the contact investigation and referral process. Stress again the importance of an examination for each contact.

d. There are two basic contact referral options:

   1. Health department referral: You (or other health care provider) assume full responsibility for informing the contact about exposure and the need for examination, and you make the referral.

   2. Patient referral: The patient agrees to inform the contact about the need for examination and to make the initial referral attempt.

e. Discuss the referral options with the patient. Ask for decisions about each person who is considered most likely to be a contact. For those the patient plans to refer, establish an understanding which defines:

   Patient's role

   Your role

   How/when the referral will be made

   Where the contact will be referred

III. Conclusion

A. Ask for and answer any questions the patient may have.

B. Evaluate remaining patient needs or potential compliance problems.

C. Review and reinforce all components of the compliance plan. Explain handouts that are given to the patient.

D. Restate the date of the next clinic visit.

E. Make arrangements for a re-interview and home visit.

F. Reinforce the procedures for referral of each contact.

G. Analyze case/contact information for inconsistencies or missing information.

H. Confront inconsistencies and apply problem solving strategies.

I. Express appreciation to the patient and close the interview.

IV. Followup

Immediately develop plans for your next interaction with the patient.

Demonstration Interview

PART II: INTERVIEWING

DEMONSTRATION INTERVIEW

DEMONSTRATION INTERVIEW

TIME: 60 MINUTES

MATERIALS/EQUIPMENT

Interview setting consisting of a table and two chairs at the front of the classroom.

Props: 1 bottle of INH
1 bottle of RIF
1 bottle of PZA
1 sputum collection/mailing kit

Handouts: Tuberculosis Interviewing Checklist
Demonstration Interview Case Study: Chandler

REQUIRED READING FOR PARTICIPANTS

None

OBJECTIVE

Participants will be able to rate a simulated interview and provide feedback about its strengths and weaknesses.

INSTRUCTOR NOTES	LESSON PLAN
INTRODUCTION Time: ______________	Our entire class time today is devoted to practice interviews. Each of you will have a turn at conducting an interview with Jake. Before you do your interviews, you'll have an opportunity to practice with each other and observe a demonstration interview. I (or other designated instructor) will do the demonstration interview. During the demonstration, you will be able to become familiar with the Interview Checklist which we will be using throughout the day.
HANDOUT Interview Checklist	I am going to pass around the Interview Checklist now. We will use the checklist for each interview that is conducted today. This is the form on which you will rate each interviewer. Here's how this works. When a participant interviews Jake, the rest of you will complete a checklist for that interview. Put the interviewer's name on the form. You do not have to put your name as the rater on the checklist. Keep all the checklists you prepare on your fellow participants so you can use them later today when you give your verbal comments and suggestions to the interviewers. You will have this opportunity when we view the videotape playback of the interviews. After we watch each taped segment and you have made you comments to the interviewer, you will give the checklist to that interviewer. Your first use of the checklist will be to critique my (or other instructor's) demonstration interview. Therefore, each of you needs one checklist for each interview that will be done today. Are there any questions about the checklist or what we have planned for today?
Distribute handout.	

INSTRUCTOR NOTES	LESSON PLAN
DEMONSTRATION INTERVIEW Time: ______________	
All of the interviews should be performed in a mock office at the front of the classroom. A table and two chairs are the only equipment needed. "Patient" and interviewer should be positioned so the class can hear and see them.	
Videotaping the demonstration interview is optional.	
Recruit in advance a participant, instructor, or clinic staff member to play the role of the patient. Give the "patient" the Demonstration Interview Case Study for advance preparation. Secretly give the "patient" some role instructions about knowledge of the disease, contacts, and attitude about having tuberculosis. You may make up your own case, or use the one provided with the material for this session.	
HANDOUT	
Demonstration Interview Case Study	
Give each participant a copy of the case study so they can become familiar with the patient's history.	
Introduce yourself in role play to the class.	Good morning. My name is ______________________.

INSTRUCTOR NOTES | **LESSON PLAN**

I work here at the ______________________ Health Department. I am a member of the tuberculosis team, and one of my jobs is to interview every new suspect or confirmed case of tuberculosis that is diagnosed in our clinic.

We have a lot of tuberculosis in ____________. Most of the patients are either diagnosed and treated in our clinic or are referred to us for treatment and followup by private physicians. Dr. Holland is our clinician and is well known and highly respected among the doctors in our community as a tuberculosis expert. I just spoke with Dr. Holland who is with a patient right now. The patient will come to my office here in a few minutes for an interview. All I know about the patient now is that he/she has a positive AFB smear, a suspicious chest x-ray examination, and that Dr. Holland has prescribed INH, RIF, and PZA. The patient will bring the medical record to my office and from that and through the interview we will learn much more.

Signal the "patient" to enter the interview room.

Perform a 20-30 minute interview. Focus on the principles and concepts of the course. Use the Expanded Outline. You will not have enough time to do a complete interview.

When you have terminated the demonstration after 20-30 minutes, ask the participants to fill out their checklists.

Explain to the class that each component of the interview outline will be developed during the practice interviews and that all participants will have a chance to do a practice interview demonstrating the skills taught in the course.

DEMONSTRATION INTERVIEW

HANDOUTS

Tuberculosis Interviewing Checklist

Demonstration Interview Case Study: Chandler

TUBERCULOSIS INTERVIEWING CHECKLIST

	YES	NO
I. INTRODUCTION		
1. Did the Interviewer establish rapport with the patient?		
2. Did the Interviewer define the purpose of the interview for the patient?		
II. BODY		
1. Did the Interviewer identify patient concerns?		
2. Did the Interviewer resolve patient concerns?		
3. Did the Interviewer adequately inform the patient about his/her diagnosis/treatment?		
4. Did the Interviewer obtain sufficient information to structure contact investigation activities?		
III. CONCLUSION		
1. Were the main points summarized?		
2. Were all of the patient's questions answered?		
3. Was a date and time established for the next interview?		
IV. FOLLOW-UP		
1. Did the Interviewer have a follow-up strategy?		

INTERVIEWER'S STRENGTHS:

INTERVIEWER'S WEAKNESSES:

COMMENTS:

DHHS:PHS:CDC:CPS:DTBC:9/87

DEMONSTRATION INTERVIEW CASE STUDY

NAME: Chandler, Matilda (F) or Leonard (M)
ADDRESS: Rt. # 2, Old Marshall Highway
________________________, ________
AGE: 35
DATE OF BIRTH: 6/13/__
MARITAL STATUS: Married. Three children.
OCCUPATION: Ward clerk (Matilda); maintenance carpenter (Leonard)
PLACE OF EMPLOYMENT: Palmer Ford Nursing Home

On Thursday of last week, the patient was evaluated by his/her private physician, Dr. Kenneth Rice. He/She gave a history of a cough of two weeks duration, loss of appetite, and sleeplessness. On the day prior to evaluation, he/she reported having coughed up blood in the early morning. Dr. Rice collected sputum specimens and sent them to the State laboratory. He called the health department and made arrangements for the patient to have a tuberculin skin test, chest x-ray examination, and clinical evaluation on Friday. At the health department tuberculosis clinic, a tuberculin skin test (0.01 ml PPD-T, 5 TU, intradermal) was administered, PA chest films were made, and sputum specimens were collected and forwarded to the State laboratory for smear and culture examination. The patient gave a history of a negative (nonsignificant) tuberculin skin test a year and a half ago when first employed at Palmer Ford Nursing Home. The patient stated that his/her paternal grandmother and a paternal great uncle had been patients at the Claxton Sanatorium about 30 years ago. The grandmother died there. The clinic nurse called Dr. Holland at her private group practice office and gave her the patient's history. The chest x-ray appeared to be abnormal and the nurse reported this to Dr. Holland. Dr. Holland gave verbal orders to start therapy with INH 300 mg., RIF 600 mg., and PZA 2 g. daily. The patient was instructed to report back to the clinic on Monday of the following week to have his/her tuberculin skin test read and to have a clinical evaluation by Dr. Holland.

The patient returned to clinic today (Monday). His/Her skin test reaction is recorded as significant at 18 mm. of induration. The chest x-ray reveals an infiltrate in the right upper lobe with cavitation. The laboratory report (on specimens submitted by Dr. Rice) indicates numerous AFB seen on smear, culture pending.

Diagnosis: Pulmonary Tuberculosis (suspect, pending culture results).

Recommendations: Continue INH, RIF, and PZA daily as prescribed. Interview patient. Make home visit. Patient not to return to work. Decision about returning to work contingent upon results of next evaluation. Return in 30 days.

DHHS:PHS:CDC:CPS:DTBC:9/87

Practice Interviews

PART II: INTERVIEWING

PRACTICE INTERVIEWS

PRACTICE INTERVIEWS

TIME: 6 HOURS

MATERIALS/EQUIPMENT

Interview setting consisting of a table and two chairs at the front of the classroom.

Props: 1 bottle each of INH, RIF, and PZA
1 sputum collection/mailing kit

Handouts: Expanded Tuberculosis Interview Outline
Interview Case Study: Jake
Tuberculosis Interviewing Checklist

Stopwatch or timer

Portable video camera

Videotape (5 hours of blank tape)

Video recorder

Video playback machine

Video monitor

(Note: It would be best if a trained video camera operator could be available to do the taping.)

REQUIRED READING FOR PARTICIPANTS

Participant Guide

OBJECTIVES

1. Participants will be able to conduct an interview using the interviewing outline.
2. Participants will receive feedback regarding their interviewing skills.

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INSTRUCTOR NOTES | **LESSON PLAN**

Before beginning this session, prepare for the videotaping.

Divide your copy of the Expanded Interview Outline into enough segments so that each participant has an opportunity to conduct one segment of the interview with Jake. Time will not permit each participant to conduct a complete interview. Determine who is to play the role of Jake. Jake may be played by an instructor, a staff member, or a participant. Arrange for time to "coach" Jake.

INTRODUCTION
Time: ______________

Each of us brings experience and background in interviewing to this course. This course offers a unique opportunity for you to actually practice interviewing so you can brush up your skills and gain feedback in a low risk, high support environment.

Yesterday we reviewed some of the principles of communication, assertiveness, problem solving, and compliance, and we looked at some of the technical aspects of conducting an interview. Today we are going to practice the application of those principles and techniques in order to improve our interviewing skills.

PRACTICE INTERVIEWS
Time: ______________

HANDOUTS

Interview Case Study: Jake

Expanded Tuberculosis Interview Outline

Interviewing Checklist

INSTRUCTOR NOTES	LESSON PLAN
Distribute the handouts. Have the class divide into pairs and ask them to read the case study. In each pair, one participant is to be the interviewer and one is to be the patient (Jake) for 30 minutes. They are then to switch roles, i.e., the first interviewer becomes the patient and the first patient becomes the interviewer. Ask the interviewers to use the Expanded Interview Outline and to practice conducting an interview with their partners. The Interview Case Study is the background information. Allow one hour for participants to practice - 30 minutes for each interviewer. At the conclusion of the practice session, ask participants to take 30 minutes to give each other feedback, using the Interviewing Checklist, and other materials previously covered in the course.	

INSTRUCTOR NOTES	LESSON PLAN

VIDEOTAPING SESSION
Time: ______________

Tell the participants in which order they will come before the class to be videotaped. Give them their interview segment assignments on the Expanded Interview Outline. One by one, the participants follow the order of the outline and conduct that portion of the interview with Jake. Example:
The first participant does I. A-D of the outline. The second participant does II. A. 1-2, and so on until each participant has had an opportunity to conduct a portion of the interview with Jake.

Allot 5 minutes for each participant's segment. Use the stopwatch or timer.

Instruct the class that while each participant is being videotaped, the rest of the class completes the Checklist. Make sure participants have enough check lists to do one for each member of the class.

After each participant has been videotaped (the entire outline should have been covered) rewind the tape and show each segment, beginning with the first participant.

Ask the class participants to give both positive and constructive feedback. Ask the videotaped participant to make observations about

INSTRUCTOR NOTES	LESSON PLAN
their own interviewing strengths and skills that need to be improved.	
Make sure that there is time to show each taped segment and time for individual feedback. Have a time schedule and stick to it! Make sure to build in breaks.	
WRAPUP Time: ____________	
Conclude the session with a class discussion of partcipants' experiences in this skill-building part of the course.	
HOMEWORK FOR TOMORROW	
	Your homework assignment tonight is to read pages ________ of your Guide in preparation for our discussion tomorrow of field investigations.
Call for questions.	
Offer your time after class for individual consultation and assistance.	

PRACTICE INTERVIEWS

HANDOUTS

Expanded Tuberculosis Interview Outline

Interview Case Study: Jake

Tuberculosis Interviewing Checklist

EXPANDED TUBERCULOSIS INTERVIEW OUTLINE

I. Introduction

A. Introduce yourself to the patient. Begin building rapport.

B. Explain your role in the tuberculosis control program.

C. Focus the patient's attention on tuberculosis. One way to do this is by saying:

"Dr. ___________ tells me that you have tuberculosis" or "I see in your medical record that Dr. __________has diagnosed you as having tuberculosis. The doctor has asked me to talk with you, as I do with all tuberculosis patients."

D. Explain the purpose of the interview:

1. To help the patient actively participate in the treatment and management of the disease so that good health is restored.
2. To identify others with infection and disease to stop the spread of tuberculosis.

Make a transition from the Introduction to the Body with a "bridge" statement/question. Examples to choose from are:

"I realize that you may already know a great deal about tuberculosis; however, today I want to go over the most important points again about this disease."

"Tell me what you have heard or read about tuberculosis. There is a lot of information about this disease that you have heard that may not really apply to your case."

"I know that you have received a lot of information about tuberculosis. What questions do you have"?

"Tell me what is the most confusing (hard, difficult to understand, hard to do, hard to remember, etc.) for you about tuberculosis."

"What will be the hardest thing for you to do that the doctor has recommended?"

"Some people find that tuberculosis is hard to deal with. What types of trouble do you expect you'll have with this disease?"

"What would help you take your tuberculosis medicine on a regular basis?"

"Why do you think some people have trouble taking their tuberculosis medicine? What would influence you the most to take your medicine?"

II. Body

A. Patient Assessment

Continue building rapport and begin problem solving.

1. Physical observation

   a. Make note of any physical signs, such as alcoholism, drug abuse, nutritional status, lifestyle, and other illnesses, that may be indicative of the patient's cooperation in the interview and have a negative effect on compliance.

   b. Observe the patient's body language throughout the interview.

2. Patient concerns

   a. Identify any patient concerns (treatment, cure, clinic appointments, protection of family members, clinic experience, etc.) Resolve those concerns now even if it means departing from the planned format of the interview.

   b. Assess the patient's intellectual level, attitudes, and needs. Begin planning what and how to tell the patient about tuberculosis, treatment, contact investigation, etc.

   c. Assess the patient's communication skills. Begin to anticipate problems. Develop potential strategies for subsequent sections of the interview.

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3. Personal information

Explain why it is important for you to have accurate personal as well as medical information in order to help.

Determine the extent of rapport developed in the interview to this point. Observe the patient and assess responses.

a. What is your full name?

b. What other name(s) do you go by? (What do your friends call you? What is your nickname?)

c. May I call you ____________?

d. How old are you? (What is your age? What is your birthday?)

e. What is your marital status? (Married, single, widowed, or divorced?)

f. Where do you live now? (Verify with drivers license, ID card, etc.)

g. How long have you lived at _______________?

h. How do you (I) get to your house/apartment? (What are the directions to your house/apartment?)

i. Where did you live before you moved to the house/apartment you live in now?

j. What is your telephone number? (Privately verify with the telephone directory before the patient leaves.)

k. Whom may I contact if I (we) need to reach you when you are not at home? (Name, address, telephone number.)

l. Who is your next of kin? (Name, relationship, address, telephone number.)

m. Where do you work (go to school)?

n. What hours do you work (go to school)?

4. Medical history and disease comprehension

a. What do you know about tuberculosis? (Do not ask this question, if you asked it in the "bridge."

Reinforce what the patient knows about the disease and correct any misconceptions.

Explain the natural course of the disease and mode of transmission using language the patient can understand. Focus on the shared air principle. Avoid giving a medical lecture.

b. When were you last examined (tested) for tuberculosis infection and disease?

c. What were the examination results?

d. When did you start coughing?

e. How frequently (how much) do you cough?

f. How much sputum do you bring up when you cough?

e. When did you first notice being hoarse or having laryngitis?

f. When did your chills and fever begin?

g. How much weight have you lost?

h. When did you notice you were losing weight?

i. Who has (or has had) tuberculosis that you think you might have been exposed to?

Discuss the patient's diagnosis and treatment recommendations (current status):

1. Tuberculin test results
2. X-ray/clinical findings
3. Smear and culture results
5. Site of disease
5. Chemotherapy recommendations

B. Transmission Interruption Behaviors

1. Take medication

   a. Explain that the drugs kill tubercle bacilli. Reinforce the personal and public health benefits of taking the medicine.

   b. Identify and explain each prescribed drug. Show the bottles to the patient. Go over the written instructions on the labels.

   c. Discuss the dosage of each drug.

   d. Establish a specific schedule for the patient to take the drugs.

   e. Discuss potential side effects.

   f. Emphasize the need to take the drugs at the times and for the length of time prescribed.

   g. Identify and discuss potential compliance problems. Incorporate strategies to enhance compliance.

2. Cover cough

   a. Instruct the patient about using a tissue to cover mouth and nose when coughing. Explain proper disposal technique. Emphasize that taking the drugs as prescribed and covering the cough are the most important measures the patient can take to protect others.

   b. Discuss venting the room air to the outside as another technique for protecting others.

3. Return for prescription refills, followup examinations, and medical evaluations

   a. Explain why the drugs are issued in 30-day supplies. Re-emphasize the importance of continuity of therapy.

   b. Explain the need for sputum and chest x-ray examinations. Discuss the approximate schedule. Show containers to the patient. Instruct the patient on collecting and submitting sputum specimens to the laboratory. Provide containers.

   c. Discuss schedule of physician and/or nurse monitoring of the patient's progress during therapy.

   d. Establish (negotiate) date and time for the next clinic visit.

   e. Identify and discuss potential compliance problems.

C. Contact Investigation

1. Introduction of the process

a. Review the patient's comprehension of the disease and the mode of transmission. Focus on the shared air principle.

b. Discuss the importance of examinations for persons who have shared air with the patient and explain the type of examination(s) they will receive.

c. Assess the patient's response to the interview thus far and determine if he/she has concerns about contact investigation activities.

2. Contact identification

a. Household environment contacts

1. How is your house/apartment heated in the cold weather months?
2. How do you cool your house/apartment in the hot weather months?
3. How many people live with you now in your house/apartment?
4. How many other people have lived with you in your house/apartment during the past six months?
5. During the past three months, how many overnight guests have you had at your house/apartment?
6. How many daytime or evening visitors, e.g., neighbors, friends, and relatives, have been to your house/apartment in the past two or three months?
7. When was the last time you were out of town?
8. On the nights when you don't go to your house/apartment to sleep, where do you spend the night?
9. How many bedrooms are in your house/apartment?
10. How many other people sleep in the same room you sleep in?

For homeless and transient patients, modify the above questions to obtain information about shelters, missions, jails, migrant camps, etc.

Use open-ended questions and ask the patient for the following information about each person now living in the household:

- Name and nickname
- Relationship to patient
- Age
- Sex
- Physical description
- Employer or school
- Other locating information.

Use open-ended questions and ask the patient for the following information about other people who have lived in the household during the recent past, overnight guests, and daytime visitors:

- Name and nickname
- Address
- Directions to residence
- Telephone number (verify with telephone directory)
- Who the person lives with
- Relationship to patient (relative, friend, neighbor, etc.)
- Age
- Sex
- Physical description
- Employer or school
- Other identifying and locating information

Analyze all the responses for conflicts in information. Identify problems and confront inconsistencies. Evaluate problems and select appropriate solutions along the way.

b. Work/school environment contacts

1. How long have you worked (gone to school) at______________________?
2. What kind of work do you do (What grade are you in) at ______________________?
3. Where do you do your work? Inside or outside?
4. (If inside) What kind of space do you work in? Enclosed or open? (Ask the patient to describe the area.)
5. How many people work in the same work space with you?
6. In addition to the employees in your work space, how many other employees do you spend time with at work?
7. What type of heating and cooling systems does your place of employment (school) have?
8. What kind of lunch and break areas does your place of employment (school) have?
9. Where do you eat lunch?
10. How (transportation method) do you get to and from work (school)?

For unemployed (not in school) patients, modify the questions to obtain information about the places (other than the house/apartment) where the patient spends time.

If the patient works in a closed indoor setting, or if the probability exists that any coworkers have been exposed, use open-ended questions and ask the patient for the following information about work associates (classmates, teachers):

Name and nickname

Address

Directions to residence

Telephone number (verify with telephone directory)

Who the person lives with

Age

Race

Sex

Physical description

Other identifying and locating information

Analyze all the responses for conflicts in information. Identify problems and confront inconsistencies. Evaluate problems and select appropriate solutions along the way.

c. Leisure Environment Contacts

1. How do you spend your spare (leisure) time?

2. Which clubs, bars, and meeting places do you go to most frequently?

3. How much time do you spend there?

4. How many people do you regularly see when you are at your club (bar, meeting place)?

5. What church do you attend?

6. Do you sing in the church choir or other musical group?

f. How many "best friends" do you have?

g. How many steady sex partners do you have?

h. Which places have you traveled to during the past two or three months?

i. When was the last time you were out of town overnight?

j. How long were you away on these trips?

k. Where did you stay?

If information about leisure activities suggests that exposure of others is a probability, use open-ended questions and ask the patient for the following information about persons with whom he/she shares leisure time:

Name and nickname

Address

Directions to address

Telephone number (verify with telephone directory)

Who the person lives with

Age

Race

Sex

Physical description

Other identifying and locating information

Sex partners including extramarital partners

Analyze all the responses for conflicts in information. Identify problems and confront inconsistencies. Evaluate problems and select appropriate solutions along the way.

NOTE: Your sensitivity to the patient's answers to the preceding questions is extremely important. Most patients will respond positively and openly; however, be prepared to begin problem solving and provide a reassuring answer if the patient asks, "Why do you need that information?" This type of response, along with nonverbal signs of discomfort, are indicators of patient concerns. Assess the degree of rapport that has been established and address any previously unexpressed patient concerns; resolve problems. Restate the purpose of the interview. Continue problem solving to deal with concerns which are commanding the patient's attention before proceeding from one segment of the interview to the next.

3. Methods of referral

   a. Inform the patient that contact investigation and referrals will be carried out immediately.

   b. Determine the patient's capability to participate in contact referrals.

   c. Inform the patient that it is sometimes necessary for site visits to be made to the home, workplace, school, leisure establishments, etc. to assess the shared air environment in order to accurately structure the contact investigation and referral process. Stress again the importance of an examination for each contact.

   d. There are two basic contact referral options:

      1. Health department referral: You (or other health care provider) assume full responsibility for informing the contact about exposure and the need for examination, and you make the referral.

      2. Patient referral: The patient agrees to inform the contact about the need for examination and to make the initial referral attempt.

   e. Discuss the referral options with the patient. Ask for decisions about each person who is considered most likely to be a contact. For those the patient plans to refer, establish an understanding which defines:

      Patient's role

      Your role

      How/when the referral will be made

      Where the contact will be referred

III. Conclusion

A. Ask for and answer any questions the patient may have.

B. Evaluate remaining patient needs or potential compliance problems.

C. Review and reinforce all components of the compliance plan. Explain handouts that are given to the patient.

D. Restate the date of the next clinic visit.

E. Make arrangements for a re-interview and home visit.

F. Reinforce the procedures for referral of each contact.

G. Analyze case/contact information for inconsistencies or missing information.

H. Confront inconsistencies and apply problem solving strategies.

I. Express appreciation to the patient and close the interview.

IV. Followup

Immediately develop plans for your next interaction with the patient.

INTERVIEW CASE STUDY

JAKE

Jake Buckner is a 37 year old male who is the office manager at Minico, Inc. Four weeks ago, he visited the company nurse complaining of fever, loss of appetite, and a cough of 2 weeks duration. The nurse suggested that he make an appointment to see his private physician. One week later, Jake was evaluated by his physician who diagnosed him with acute bronchial infection and prescribed an antibiotic and decongestant cough formula. He continued to work although his symptoms persisted, but he took 2 days of sick leave and left work early twice because of fatigue. Last Monday Jake returned to his physician. He was still coughing and had lost a total of 9 pounds. The physician referred him to a radiologist for a chest x-ray examination. The chest x-ray, which was read on the same day, showed a subapical infiltrate in the left lung. Jake's physician called the city health department and made arrangements for him to be seen on Tuesday for an evaluation. At the health department, Jake was given a Mantoux tuberculin skin test and sputum specimens were obtained. The clinician, after reviewing Jake's history, clinical findings, and chest x-ray, prescribed isoniazid (INH) 300 mg., rifampin (RIF) 600 mg., and pyrazinamide (PZA) 2 g. daily. He instructed Jake to return to the clinic on Thursday to have his skin test read and to get his laboratory report.

Thursday: Jake returned to the clinic. The nurse read his tuberculin skin test as 15 millimeters of induration. The laboratory report indicated numerous acid-fast bacilli seen on smear, culture pending. The clinician made a presumptive diagnosis of pulmonary tuberculosis and instructed Jake to continue the medicines that were prescribed the day before yesterday. The clinician sent Jake with his record to your office for an interview.

DHHS:PHS:CDC:CPS:DTBC:9/87

TUBERCULOSIS INTERVIEWING
CHECKLIST

	YES	NO
I. INTRODUCTION		
1. Did the Interviewer establish rapport with the patient?		
2. Did the Interviewer define the purpose of the interview for the patient?		
II. BODY		
1. Did the Interviewer identify patient concerns?		
2. Did the Interviewer resolve patient concerns?		
3. Did the Interviewer adequately inform the patient about his/her diagnosis/treatment?		
4. Did the Interviewer obtain sufficient information to structure contact investigation activities?		
III. CONCLUSION		
1. Were the main points summarized?		
2. Were all of the patient's questions answered?		
3. Was a date and time established for the next interview?		
IV. FOLLOW-UP		
1. Did the Interviewer have a follow-up strategy?		

INTERVIEWER'S STRENGTHS:

INTERVIEWER'S WEAKNESSES:

COMMENTS:

DHHS:PHS:CDC:CPS:DTBC:9/87

Part III: Field Investigation

PART III: FIELD INVESTIGATION

FIELD INVESTIGATION

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OVERVIEW OF PART III: FIELD INVESTIGATION

"Part III, Field Investigation" presents an opportunity for participants to also be instructors; they will learn from each other through their discussions and other interactions. You are to adopt the role of group facilitator. Using the Study Guide Questions which are at the end of the reading assignments in the Participant Guide, your job is to get the participants involved in a discussion of the subject matter. The Study Guide Questions are woven into the lesson plan procedures in your Guide. If you need guidance in conducting these sessions, refer to numbers 11 - 15, p. v, Orientation for the Instructor.

The discussions should not be limited to participants' answering the questions only. Encourage them to discuss related issues and problems and talk about personal experiences. The discussions should be connected to the topic before the class at that time.

It is essential for you to read the material for each session in the Participant Guide. Be prepared to amplify on the readings as well as the comments participants make in class. A very general lesson plan is provided in your Guide. Use the flip chart to record key points.

We have recommended a total of 5 hours, 15 minutes for Part III on the Timetables and Sample Agenda. It will be up to you to determine how much time to actually devote to each session and to develop a specific schedule.

The only equipment you need for Part III is the flip chart. Have enough marking pens on hand for the Safety session.

INTRODUCTION TO FIELD INVESTIGATION

REQUIRED READING FOR PARTICIPANTS

None

INSTRUCTOR NOTES	LESSON PLAN
Time:	You are required to investigate, locate, refer, provide services (e.g., directly observed therapy), and carry out a variety of other field activities for diagnosed cases, suspects, contacts, and persons on preventive treatment. A number of challenges will inevitably occur which demand your quick, knowledgeable response. Most of this day is devoted to paying attention to the most common problems you are apt to face when working in the field. Since each of you already has a wealth of information and experience, I will count on you to be both "participant" and "instructor" during most of our sessions in Part III. These are really a "how-to" sessions. Let us know about strategies you have found to be successful when you work in the field. We can also learn from your mistakes, if you are willing to share them.
FLIP CHART	
	What are some of the thorniest situations you have faced when conducting a field investigation?
List the situations on the flip chart. Mention which ones will be covered in today's session.	
	We will use our sessions today to cover the following situations: Objectives of field investigations; Approaches to the field resource person; Approaches to third parties;

Encounters with clients in the field;

Finding people with questionable address information;

Use of the telephone;

Safety in the field;

Documentation; and

Working with private physicians.

So, let's get started!

OBJECTIVES OF THE FIELD INVESTIGATION

REQUIRED READING FOR PARTICIPANTS

Participant Guide material for this session.

OBJECTIVE

Participants will be able to list objectives of a field investigation.

INSTRUCTOR NOTES	LESSON PLAN
Time: ______________	
FLIP CHART Write the objectives on the chart in advance.	The objectives of a field investigation are: To make sure the client: 1. Knows what disease is involved; 2. Believes the information is true and correct; 3. Understands what medical options are available; 4. Is motivated to act promptly and appropriately; and 5. Actually responds and receives medical care.
	What do we mean by the first objective? Give an example of how you can do this. What do we mean by the second objective? Give an example of how you do this. What do we mean by the third objective? Give an example of how you do this.

INSTRUCTOR NOTES	LESSON PLAN
	What do we mean by the fourth objective? Give an example of how you do this. What do we mean by the fifth objective? Give an example of how you do this. What kinds of problems have you had accomplishing the first objective with your clients? How did you resolve the problems? What kinds of problems have you had accomplishing each of the other objectives? How did you resolve the problems?
Permit as much discussion possible within the amount of time you have allocated for this session.	

APPROACHES TO THE FIELD RESOURCE PERSON

REQUIRED READING FOR PARTICIPANTS

Participant Guide material for this session.

OBJECTIVE

Participants will be able to discuss how open-ended questions can be deployed as a powerful technique in gaining information from resource persons in the field.

INSTRUCTOR NOTES	LESSON PLAN
Time: ______________	Open-ended questions represent a powerful technique for getting information from resource persons in the field. Why is it important to ask questions in such a way that the field resource person does not answer "No"? "No" enables the person to end the conversation, and you will not get the information you need.
ROLE PLAY Role play with three participants. You play the role of the child, neighbor, and clerk. The participants (the health care providers) are to get the information from you. Answer "No" each time the question is close-ended. Respond appropriately to the open-ended questions in order to engage in a dialogue with the health care provider.	

INSTRUCTOR NOTES	LESSON PLAN
Call on each person who is playing the role of the health care provider.	
	Give us an example of an open-ended question you might use when looking for Jake and you are talking to: A small child playing in the area; A neighbor; A neighborhood store clerk.
Critique each of the interactions. Call for comments about the effectiveness of each health care provider's interaction with the three field resource persons you played.	
	What are some of the other techniques you use to get information from a field resource person?
Permit as much discussion possible within the amount of time you have allocated for this session.	

ENCOUNTERS WITH TB CLIENTS IN THE FIELD

REQUIRED READING FOR PARTICIPANTS

Participant Guide material for this session.

OBJECTIVES

Participants will be able to describe how they will respond to the following challenging situations in the field: (1) identifying the correct person; (2) handling confrontation; (3) communicating with a client when he/she is not at home.

INSTRUCTOR NOTES

Time: ______________

LESSON PLAN

Why is it important to make sure you are talking with the right person when you are in the field?

Remember to ask open-ended questions. Start questions with who, what when, where, why, how.

What problems have you had as a result of speaking with the wrong person? How did you deal with those problems?

There are two basic approaches you can use when you encounter clients in the field: the direct approach and the indirect approach.

What do we mean by the direct approach?

Give an example of an interaction with a client in the field using the direct approach.

How many of you use the direct approach?

What are its advantages? Disadvantages?

What do we mean by the indirect approach?

Give an example of an interaction with a client in the field using the indirect approach.

INSTRUCTOR NOTES	LESSON PLAN
	What are its advantages? Disadvantages?
ROLE PLAY	We can expect confrontation questions and statements from some of our clients. For example, when we tell a nonfamily contact that he/she has been exposed to tuberculosis, we may expect a series of questions or statements in response. We are going to do a quick role play. I am the contact. You have just come to my house and told me that I have been exposed to tuberculosis.
CALL ON PARTICIPANT	1. My response to you is: Do I have tuberculosis? What are you going to tell me?
CALL ON PARTICIPANT	2. My response is: I haven't been around anyone with TB. What do you say to me?
CALL ON PARTICIPANT	3. My response is: I feel fine. What is your response?
CALL ON PARTICIPANT	4. My response is: There isn't anything wrong with me. I went to my doctor last week and he said I was fine. What do you tell me?
List innovative responses on the flip chart.	

INSTRUCTOR NOTES	LESSON PLAN
	What do you do when you find the client is not at home? How do you leave a written message? Give examples of what you might write in a note to a contact who has been newly exposed to tuberculosis.
Permit as much discussion possible within the amount of time you have allocated for this session.	

FINDING PEOPLE WITH QUESTIONABLE ADDRESS INFORMATION

REQUIRED READING FOR PARTICIPANTS

Participant Guide material for this session.

OBJECTIVE

Participants will be able to state the course of action to be taken for locating people with an uncertain, incomplete, or inaccurate address.

INSTRUCTOR NOTES	LESSON PLAN
Time: ______________	
	What do you do when you are looking for someone in the field and you discover you have been given the wrong address?
FLIP CHART These are the answers you are looking for. Try to elicit others.	Check the names on mail boxes. Ask people in the houses or apartments on either side. Transpose the address numbers and/or directional prefixes. Ask people who may be willing to help, e.g., the mail person, neighbors, neighborhood leaders, apartment managers, people congregating in the area, children, managers or employees of neighborhood stores, shops, etc. Check hospital/clinic records. Talk with next of kin. If contacts, go back to the source case.

INSTRUCTOR NOTES	LESSON PLAN PROCEDURES
	How can it help in doing the field investigation to have a description of the house or building the client lives in? Give an example.
	What are some other special techniques for locating people with uncertain, inaccurate, or incomplete addresses?
Permit as much discussion possible within the amount of time you have allocated for this session.	

APPROACHES TO THIRD PARTIES

REQUIRED READING FOR PARTICIPANTS

Participant Guide material for this session.

OBJECTIVE

Participants will be able to practice interacting with clients, their families, friends, and coworkers under challenging circumstances.

INSTRUCTOR NOTES	LESSON PLAN
Time: ______________	
	We frequently have to talk with third parties when we are working in the field. Some of these persons can present challenges to our ability to accomplish our mission. At times we have to deal with third parties who are uncooperative, obstructive, or inquisitive. In this session, we will look at some ways of handling these situations.
ROLE PLAY During this session, you will be involved in a role play exercise with the class. Your job is to play the role of the person described in each exercise. Call on individuals to respond to you as they would as health care providers in an actual interaction.	

CALL ON PARTICIPANT

ROLE PLAY #1

You are the TB health care provider. You have come to my house looking for my spouse who is a close contact of an infectious case of tuberculosis. The case is the bar maid at the Rex Bar and Grill. What do you say to me when I answer the door. (Be cooperative.)

CALL ON PARTICIPANT

ROLE PLAY #2

You are from the health department. The person I am living with now has been exposed to tuberculosis. The recently diagnosed patient is a prostitute. You come to our apartment. I answer the door. What do you say to me? (Be inquisitive; try to find out personal information about the case.)

CALL ON PARTICIPANT

ROLE PLAY #3

You are the health care provider. I am a the parent of a 10-year old child. My child has been exposed to tuberculosis on the school bus. The driver was diagnosed just yesterday. You have come to inform me of the exposure and to arrange for skin testing my child. What do you say to me? (Be inquisitive about the source; unconcerned about skin testing.)

CALL ON PARTICIPANT

ROLE PLAY #4

When I got home from work last night, a friend who lives down the street called me and told me that the woman who lives on the next street has TB. You are from the health department, and just as I am coming in from work, you ring the door bell. You have come to inform my unemployed husband that he is a contact of an infectious

INSTRUCTOR NOTES	LESSON PLAN
	case of tuberculosis. What do you say to me when I answer the door? (Be inquisitive, hostile, and uncooperative.)
CALL ON PARTICIPANT	
	ROLE PLAY #5 I have a friend who has tuberculosis and the doctor says he can't go back to work. He'll probably lose his job. My roommate and I are very concerned about our friend, because he needs to work. My roommate has been coughing and losing weight. She went to a clinic yesterday and they ran some tests. You have come from the health department to give my roommate an appointment to come back to the clinic. She hasn't come home from work yet, but I know she is afraid of getting sick and losing time at work - maybe even losing her job. What do you say to me? (Be cooperative, but anxious.)
CALL ON PARTICIPANT	
	ROLE PLAY #6 I have been telling my 15-year-old daughter she can't associate with Otis. I don't like Otis and the friends he hangs out with. The word around our building is that Otis' father is in the hospital with TB. You are assisting in the contact investigation of another case which happens to be one of my daughter's part time coworkers at Burger Driv-thru. She is still at work when you come to our door. What do you say to me? (Be angry, threatening, and inquisitive.)
Briefly critique each participant's performance as the health care provider in the role plays.	
	Who has had similar or other problems in the field with uncooperative or obstructive third parties? How did you handle it? In retrospect, would you handle it the same way, or differently?

INSTRUCTOR NOTES	LESSON PLAN
	When you visit or telephone a client's work place, how do you go about approaching third parties? If the only locating information you have is a bar or hangout, who would you ask for information or help and how?
Permit as much discussion possible within the amount of time you have allocated for this session. Summarize the key points of this discussion on the flip chart.	

USE OF THE TELEPHONE IN THE FIELD INVESTIGATIONS AND REFERRALS

REQUIRED READING FOR PARTICIPANTS

Participant Guide material for this session.

OBJECTIVES

1. Participants will be able to describe how the telephone can be a useful tool in field investigation.
2. Participants will be able to practice handling difficult telephone conversations.
3. Participants will receive feedback regarding their telephone skills.

INSTRUCTOR NOTES	LESSON PLAN
Time: ______________	
	Now we are going to talk about using the telephone in field work.
	How can you save time by using the telephone?
	It takes less time than traveling. It's also less expensive than traveling.
CALL ON PARTICIPANT(S)	
	What would you say over the phone to a newly exposed contact?
Ask for the reactions of the other participants to this provider's telephone conversation with the contact.	
	What would you say to a patient on treatment who has failed to show up for an appointment?
As for the reactions of the other participants to this provider's telephone conversation with the patient.	

INSTRUCTOR NOTES	LESSON PLAN
ROLE PLAY	
	Let's have some fun now with a telephone role play.
Count participants off: 1, 2, 3. Instruct each group of three to put two chairs back to back. Have them place a third chair to the side. For each group of three, one person is to volunteer to be the client; one person is to be the health care provider; and one person is to be the observer. The provider and the client are to sit back to back. The observer is to take the side chair.	
	Here are your job descriptions. The health care provider is to try to convince the client to come to the tuberculosis clinic today. The client is to respond to the provider. Clients, go for an academy award in playing your role. Listen carefully in a minute when I tell you who your character is. Remember this is a telephone conversation. The observer is to listen to the conversation between the provider and client and prepare to make a brief verbal report to the class. Each group has five minutes for this "pretend" telephone conversation. Observers will have one minute each to report your observations to the class.
There are eight different scenarios. Assign one to each group of three.	
	1. The client is an alcoholic patient who has already missed three appointments.

INSTRUCTOR NOTES	LESSON PLAN
	2. The client is a household contact with three children who are also contacts; she has failed to keep an appointment for skin testing.
	3. The client is a patient on therapy who does not feel well, but does not go back to see the doctor.
	4. The client is a busy teenager who has failed to come in for a re-issue of INH preventive therapy.
	5. The client is a suspect with positive AFB smear who is irritated by your calls and visits.
	6. The client is an out-of-work high school drop-out who has a suspicious chest x-ray examination.
	7. The client is an elderly male patient on therapy for disease who is afraid to go outside of the house because it is in a high crime neighborhood.
	8. The client is a contact who has just been released from prison where he was exposed to a cell mate who has been diagnosed as a case.
It is not necessary to use all of the case studies. Use one case study per group.	
Reconvene the class after five minutes.	
	Starting with the observer for Group 1, I would like each observer to give a one-minute summary of your observations.
Following the reports, call for comments and questions about each provider's telephone techniques.	

INSTRUCTOR NOTES	LESSON PLAN
	Sometimes as health care providers, we answer the telephone and the caller says that he/she has received a written note to call the health department. Frequently, the client will be one who has been contacted by a coworker. What do you do when you get such a call? Excuse yourself to get the record to find out why the client was visited. Tell the client what to do based on the clinic record.
FLIP CHART	Visualize yourself at the office. The telephone rings, and the caller asks to speak with your coworker who is out of the office. What kind of information should you write down as a record of the phone call you take for the coworker?
Write down all valid responses. Keep asking "What else?" until you get these responses.	Your name as the message-taker. Client's name. Date and time of call. Client's correct name, address, telephone number. Where and when the client can be reached. When the client will come in to the clinic. Other pertinent information.
FLIP CHART	What kinds of problems have you had in using the telephone to talk to clients or in taking messages? What are some reasonable solutions to these problems?

INSTRUCTOR NOTES	LESSON PLAN
List the problems and solutions on the flip chart.	Telephone Calls Problems Solutions
Permit as much discussion possible within the amount of time you have allocated for this session.	

SAFETY IN THE FIELD

REQUIRED READING FOR PARTICIPANTS

Participant Guide material for this session.

Lewis ID, Hallburg JC. Strategies for safe home visits. Urban health. 1980.

OBJECTIVE

Participants will be able to list at least five principles for assuring greater safety for public health workers in the field.

INSTRUCTOR NOTES	LESSON PLAN
Time: ____________	
	This session is about safety in the field. Attention to personal safety is a very important consideration in our work, because from time to time we may be in situations that are potentially dangerous.
CALL ON PARTICIPANT(S)	Describe incidents when you or a coworker have encountered danger when working in the field.
Allow three or four people to respond. If no one can relate a personal experience, ask them to tell about dangerous experiences they have heard about.	
FLIP CHART	Who can be a problem? What can be a problem? Where can the problem occur? When can the problem occur? Why does it happen?

INSTRUCTOR NOTES | **LESSON PLAN**

We are going to talk about who, what, where, when, and why in relation to danger problems that can occur in the field.

FLIP CHART

Address each question already on the flip chart. Call on participants for answers. When you are finished, the flip chart should look something like this.

Possible Answers

Who?	Alcoholics	Gangs	Rapists
	Drug users	Robbers	Mental cases
What?	Robbed	Sexually assaulted	
	Beat up	Harassed	
Where?	Streets	Alleys	Dark stairs
	Ghettos	Taverns	Dark halls
	Under bridges		Isolated areas
	High crime areas		
When?	Late in the day	After school	
	At night	Pay day	
Why?	Working alone	Antagonized client	
	Wrong address	Getting cornered	
	Walking into an obviously dangerous situation		

There may be other responses. List all that are valid.

Almost everyone who has ever done public health field work believes that safety can be a problem.

INSTRUCTOR NOTES	LESSON PLAN
GROUP EXERCISE Time: 30 minutes Divide the class into groups of four.	
	This is a "real life" exercise. Let's imagine each one of you has been asked to serve on a Blue Ribbon Task Force. For the sake of our discussion, suppose the Governor (or Mayor) is very concerned about the safety of public health employees who work in the field. The Governor (or Mayor) has heard that TB health care providers may be working in dangerous situations. The Governor (or Mayor) has asked the Blue Ribbon Task Force to come up with 5-10 recommendations or principles for public health workers to use in order to avoid trouble and danger that could result in personal injury on the job. Each group is a separate Blue Ribbon Task Force. We have already listed on the flip chart the who, what, where, when, and why of the problem. Your charge is to come up with the 5-10 recommendations for protection of public health workers in the field. These will be submitted to the Governor (or Mayor). You have 20 minutes to develop your recommendations.
Send the groups to separate rooms or to separate corners of the classroom. Give each group a marking pen and several sheets of flip chart paper.	
	Write your final recommendations on the paper. Each group will make a verbal report to the class (the Governor or Mayor) at the conclusion of your Task Force meetings. Each Blue Ribbon Task Force should select a chairperson and a secretary to record the recommendations on the flip chart paper. Each Blue Ribbon Task Force now has 20 minutes to come up with recommendations. What questions do you have about your assignment?

INSTRUCTOR NOTES	LESSON PLAN
After 15 minutes, remind the Task Forces that they have 5 minutes left.	
Bring the groups back to their original seats.	
Ask each secretary to tape the recommendations to the wall.	
Ask each chairperson to present the Task Force Recommendations in turn.	
Invite group members to present additional comments.	
Permit as much discussion possible within the amount of time you have allocated for this session.	
Conclude the exercise with a statement from the Governor (or Mayor).	
	"I speak for the Governor (Mayor) when I say that each Task Force has done a thorough and excellent job. The Governor (Mayor) is very pleased."

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE

Strategies For Safe Home Visits

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Traditionally, the needs of chronically-ill patients, especially those in urban, poor areas, have been served largely by well-educated and highly skilled public health nurses and visiting nurses. Today this is no longer true. Cost containment, technological advances, changes in illness and health care, and an increasingly larger population of older citizens have all contributed to a rapid increase in the number of "new providers" of community health care.

Today, novice nurses, "new non-traditional" health workers, and data collectors are more and more frequently providing services in communities unfamiliar to them, particularly poor, urban residential areas. To aid in the protection of these health workers as they encounter potentially dangerous settings, this article discusses basic assessment skills and identifies some preventive strategies for use when threatening or potentially threatening situations arise.

The influx of "new" health workers includes undergraduate nursing students who are not being trained as public health nurses, as well as home health aides, community health workers, clinical pharmacists, graduate students doing research in health, and others. Such an influx has come in part as a result of recent emphasis on ambulatory care and active outreach programs designed to assist the chronically ill in managing their regimen.

The assessment techniques and tactics presented here are based upon data drawn from interviews with competent public health nurses and experienced nurse researchers. Both groups of nurses employed these skills and tactics in the absence of a two-way communication system (e.g., beepers, or two-way radios) between themselves and their agency.

AT-RISK SITUATIONS

Although there are many possible "at risk" situations in home visits, we have chosen to limit our description to three types in which the personal safety of a home visitor may be in jeopardy. These situations may or may not be mutually exclusive. (1) Home visits to single-room occupants (SROs) in an area with a highly transient population where drug and human abuse are not uncommon, e.g., San Francisco's Tenderloin district; (2) Home visits to a community that differs economically, culturally, and ethnically from the visitor's community, e.g., a white middle-class visitor in a black lower-class community, or an Asian middle-class visitor in a white lower-class community; and (3) Home visits by an inexperienced visitor whose purpose is to collect information and whose patient is an experienced and mature person, e.g., a clinical pharmacists's visit to make a pill count or take blood pressure reading, or a novice researcher's visit to conduct an interview.

Given these three general "at-risk" conditions, several basic assessments should be made by a "new non-traditional" worker. First should be the collection of as much recent data as possible regarding the physical status of the district prior to the home visit. Data should be collected from as many varied sources as possible within a realistic time frame. The worker should also consciously assess her/his feelings and beliefs, and consider any past experiences under conditions similar to those expected to be encountered during the visit.

Let us now consider a high-risk district with a history of transient residents, where many SROs live and where there are subcultures of low socio-economic status amid evidence of drug abuse. What must a worker consider within the parameters of an adequate assessment?

ASSESSMENT OF LOCATION

Begin by asking co-workers, supervisors, instructors, and others to describe the district in which patient resides. Then locate the patient's address on a city map. Inquire about previous outcomes and experiences in this district and adjoining districts. When approaching the neighborhood, note the physical appearance of buildings surrounding the residence of the SRO, and evaluate the physical appearance of the SRO's residence. Has it been recently painted? What is the condition of the doors and windows? What is the general appearance of the street and grounds in front of and near the patient's residence? Are they neat and orderly?

Once inside the patient's residence note whether the outside door of the building is "open to the public," or whether there is some measure of controlled access. If it is a hotel or rooming house, observe the presence or absence of a desk clerk on duty in the lobby. Is there a sign-in and sign-out book at the clerk's desk? Observe the presence or absence of people in the lobby. If present, what is their appearance, and what are they doing? What general age and sex are they? What does the lobby look like? Are there doors? What do the doors suggest? Note the means of access to upper levels. Is it via stairs, elevator, or both? What is the visibility from inside the elevator or on the stairways?

SELF-ASSESSMENT

It is important for the worker to be aware of her/his own role and contributions to any given situation. Prior and existing values, mores, beliefs, and involvement in similar experiences do impinge upon the interaction of comfort, discomfort, and sense of vulnerability in any given setting. This demands an objective assessment of feelings and capabilities by the worker.

An inexperienced worker may be unfamiliar with the norms, social distancing, social interaction patterns, and jargon of the patient, and thus misread the patient's communications. Therefore, to ensure the visit's safe outcome, the worker may need to lay some ground rules or set the stage to seek clarification at the outset of the visit. In this way, the worker is being fair and "upfront" with herself/himself and with the patient.

PATIENT ASSESSMENT

Prior to making the visit, read the patient's chart, if available, for pertinent background; e.g., history of alcohol or other drug abuse, source of income, age, birthplace, ethnicity, educational level, etc.

Once inside the patient's room, note its general appearance. Is it neat, or is it disarrayed? Note the presence of any odors, beer cans, or alcoholic bottles. Observe the types of pictures on the wall, if any. Note the location of exits from the room. Make an assessment of the patient's dress, e.g., pants and shirt, or undershirt and pants, etc. Note also patient's general personal appearance and body hygiene. Finally, observe where the patient sits and where she/he suggests you sit.

PREVENTIVE TACTICS

Now, let us consider preventive tactics which a worker may use to maximize safety of a home visit. Again, an at-risk setting is suggested in a district where people on the streets exhibit atypical behavior and unpredictable actions, e.g., shouting at passers-by or moving their hands in a boxer-like manner while walking down the street, or others who just seem to "hang out" on streets where many businesses are boarded-up.

PREVENTIVE TACTICS

An excellent strategy to assure a safe home visit is to plan for it well in advance. Here are some suggestions others have found useful: (1) Make certain you have established a goal or goals for the home visit. Plan to make your purpose clear and precise at your arrival. (2) Plan an early morning visit, e.g., 9:00 - 10:00 a.m., to get into and out of the district prior to the gathering of many of the "street people". Evening visits should be made by two persons. (3) Engage in a role-playing exercise in which one worker plays herself/himself, and another plays the patient. Practice what not to say, as well as what to say, and how to act versus how not to act. (4) Establish an "alerting system," and pre-plan the length of your visit. Arrange to check with someone before and after an "at-risk" home visit. For example, a worker can telephone the office 5 to 10 minutes before and after such a visit.

There are also guidelines which should be followed upon arrival at the patient's residence. Leave unnecessary items in your car, and put valuable items out of sight prior to parking in the district. When on the streets, carry items close to the trunk of your body. Hold an item such as a shoulder bag with one hand. Place your hand on top of or about the bag and press it against your body. Carry your tape recorder, blood-pressure kit, or other equipment in a similar fashion - always close to your body.

Once inside the patient's residence, rest your handbag or other item upon your lap, or rest it against your feet. Sit only in a chair, preferably facing the patient. Do not sit upon the bed.

Inform the patient of your time schedule early in the visit. Adhere to your time plan with a five to ten minute flexibility.

If uniforms are not required, do not wear casual clothes, e.g., blue jeans. Instead, wear a suit or daytime dress with stockings and dress shoes. Use a mild perfume or cologne, if any. This attire connotes a businesslike interaction. If the nurse wears casual attire, the patient may perceive that a non-businesslike interaction is appropriate to pursue. On the other hand, overdressing might also be perceived by the patient as basis to pursue a non-businesslike interaction.

If the planned visit is an evening one, then visiting in pairs is recommended. Use of an alerting system immediately before and after the encounter is also important. Planning the visit so that each health worker can learn from the experience should be a pre-arranged goal and outcome.

If transportation is by car, park under a street light. Don't open the car door is a person is approaching, or has just passed. Instead, wait till all persons are 50 yards or more away from the car. While seated inside, keep the doors locked. Use the same caution when returning to the car to re-enter and exit from the area. If transportation is by bus, plan to make any and all transfers in well lighted, less "at-risk" communities, even if such precautions make the ride longer.

ABORTING A "SOUR HOME VISIT"

Here are some simple tactics to assist in the exit from perceived unsafe situations. Once inside, a home visitor has to assess, plan, act, and react in an ongoing, dynamic way.

Use of the self is key when confronted with these risky conditions. If the patient who welcomes you is not dressed in street clothes and is of the opposite sex, wait at the door and request that the person dress prior to your entry.

Once you are inside, if the conversation is frequently redirected from your stated purpose, persist with a brief, but focused, explanation of your mission. If this approach fails, then explain your intent to leave and proceed to do so. Make it very clear that you are expected in your office to meet with a specific person within 15-20 minutes. Be firm and avoid displaying any evidence of fear, e.g., voice changes, hands shaking, etc. Always be firm, and make slow, yet deliberate movements toward the exit.

"New non-traditional" health workers must be aware of the explicit, yet subtle cues in high-risk home-visit situations that more experienced community health workers have long known. These "new" health workers should also possess a repertoire of preventive tactics from which they can draw when necessary to help ensure their own personal safety in high-risk situations. If home visits actually do become unsafe, health workers need to know a series of pragmatic steps to take, in order to extricate themselves safely from any threatening situations.

REFERENCE

Lewis, I.D.: *Management of Chronic Hypertension by Black Clients.* Unpublished Doctoral Dissertation. University of California at San Francisco, 1978.

DOCUMENTATION

REQUIRED READING FOR PARTICIPANTS

Participant Guide material for this session.

OBJECTIVE

Participants will be able to document on the appropriate forms the work performed on an investigation and referral.

INSTRUCTOR NOTES	LESSON PLAN
Time: ____________	
	Why is documentation of investigations and referrals necessary? As public health employees, it is important for us to keep records and notes so that we can remember what we have done and what we have to do. How many of you have a system for recording field investigation and referral activities? How do you document your field work? Describe your system. What kinds of problems or barriers keep you from making notes? What are some examples from your experience of how good notes helped an investigation? What are some examples from your experience of how lack of notes hindered an investigation or referral?
Allow as much discussion possible within the amount of time you have allocated for this session.	

APPROACHES TO PRIVATE PHYSICIANS

REQUIRED READING FOR PARTICIPANTS

Participant Guide material for this session.

OBJECTIVE

Participants will be able to describe at least one new strategy for attaining information from private physicians.

INSTRUCTOR NOTES	LESSON PLAN
Time: ____________	
FLIP CHART	**Contacting private physicians and other providers.** 1. Followup of laboratory or case reports. 2. Inform a physician a client is coming in to see him/her. 3. Obtain treatment or followup information. 4. Verify information a client has given. 5. Give feedback about clients.
	I have listed on the flip chart some of the reasons we contact other health care providers about tuberculosis clients. What other situations make it necessary to contact a private physician, hospital, or other provider? How do you ask a private physician for information you need about a client?

INSTRUCTOR NOTES	LESSON PLAN
	What problems have you had getting information from private physicians? Describe the problems. How did you resolve these problems? Who can suggest some alternate solutions to the problem(s) we just heard about? What are some of the strategies you have found to be effective for obtaining private physicians' cooperation?
Permit as much discussion possible within the amount of time you have allocated for this session. Summarize key discussion points on the flip chart.	

Self-Assessment

SELF-ASSESSMENT

DHHS:PHS:CDC:CPS:DTBC:9/87

SELF-ASSESSMENT

TIME: 60 MINUTES

MATERIALS/EQUIPMENT

Handout: Self-Assessment Form

OBJECTIVE

Participants will be able to assess their current interviewing, investigating, and influencing skills and will develop an action plan for improving or sustaining their skills.

The intent of the self-assessment session is for participants to come up with a realistic, do-able action plan that they can implement when they return to work.

HANDOUT

Self-Assessment form

Distribute the handout.

Explain the form.

Ask participants to work independently.

Check with participants 45 minutes into the session to see how close they are to finishing. Before the session is wrapped up, each participant should have a "Dear Boss" letter in draft form.

Reconvene the class and ask participants to share at least one action step they plan to take once they get back to work.

It is not necessary for you to collect the assessments and letters. Encourage participants to review them from time to time as a way of keeping their commitments to themselves in mind.

SELF-ASSESSMENT

HANDOUT

Self-Assessment Form

INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL

SELF-ASSESSMENT

I. Skill Rating

For each skill listed below, rate yourself (one number between 1 and 10) and list the actions you plan to take to improve or sustain that skill.

Skill	Rating - + 1---- 10	Action steps for future skill enhancement
1. Nonverbal communication		
2. Listening		
3. Obtaining complete, accurate information from clients		
4. Giving information that persuades clients to take positive TB control action		
5. Self-confidence		
6. Confronting clients' problems		
7. Relating to third parties in the field		

Skill	Rating - + 1---- 10	Action steps for future skill enhancement
8. Using field resource persons		
9. Finding people with questionable addresses		
10. Handling clinic referral slips and notes		
11. Documenting your investigations and referrals		

II. Role Analysis

Review the interviewing, investigating, and compliance influencing activities that you are responsible for at work. List those and other functions here.

____ ______________

____ ______________

____ ______________

____ ______________

Other ____ ______________

____ ______________

____

100%

Now think about the amount of time you spend on each. Write in the percentage of time you spend on each function. The total should add up to 100%.

Do these percentages reflect the investment you should be making?

Now list the percentages again.

Record the way (expressed as a percentage) you think your time should be distributed under optimum conditions.

Functions	% Now	% Optimum
Other		
	100%	100%

Describe your strategy for changing the situation as it is now so that it comes closer to the optimum.

Action Steps:

III. In one brief paragraph or list, describe how you plan to conduct interviewing, investigating, and compliance influencing activities differently now that you have had the opportunity to look at these critical aspects of your job.

What resources, support, permissions, etc. will you need to make these changes?

IV. Use a clean sheet of paper and write a "Dear Boss" letter. Thank your boss for sending you to this course. Include in your letter a brief report based on your action plan; discuss what you intend to do or change as a result of this training.

Post-Course Test

POST-COURSE KNOWLEDGE ASSESSMENT

DHHS:PHS:CDC:CPS:DTBC:9/87

POST-COURSE KNOWLEDGE ASSESSMENT AND COURSE FEEDBACK

TIME: 60 MINUTES

MATERIALS

Handouts: Post-course Knowledge Assessment Form
Participant Rating Sheet
Participant Feedback Form
Certificates

OBJECTIVES:

1. Participants will be able to measure knowledge gained as a result of attending this course.

2. Participants will give their comments about the ways this course was effective in meeting objectives and about the ways it could be improved.

INSTRUCTOR NOTES	LESSON PLAN

HANDOUTS

Distribute the Post-course Knowledge Assessments, Participant Rating Sheets, and Participant Feedback Forms.

Announce that one hour is allotted to complete all three. Participants should be given additional time, if they need it.

Participants are to take only the parts of the Knowledge Assessment which they covered in the course.

Determine in advance and announce how you plan to administer the Pre-and Post-course Knowledge Assessments. There are several options from which you may choose:

Supply an answer sheet and let the participants mark their own assessments before leaving class.

Mark the Pre-course Knowledge Assessments prior to the last day and return them to participants after they have completed the Post-course Knowledge Assessment.

Collect the Post-course Knowledge Assessments as they are turned in, mark them and the Pre-course Knowledge Assessments and return them to participants at a later date.

If participants mark their own Assessments, ask them to record their Pre-course and Post-course Knowledge Assessment scores. These are to be turned in to you.

Ask participants to be candid when completing the Participant Feedback Form and to complete the entire form. Explain that their comments are important in keeping the course current and making improvements. They need not sign the form. Ask them to turn in the completed evaluation forms when they turn in their tests.

Thank the participants for their contributions to the course and for their feedback.

Award the certificates. You may want to do this individually as participants turn in their tests and feedback forms.

If you have no other course business, you may send the participants home as soon as they turn in their tests, rating sheets, and feedback forms.

Participants should keep their notebooks for reference.

Please fill out the Instructor's Report of Training Course form and send it to us within the next 10 days.

Many thanks!

POST-COURSE KNOWLEDGE ASSESSMENT

HANDOUTS

Post-course Knowledge Assessment Form

Participant Rating Sheet

Participant Course Feedback Form

Certificates

INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL

____PRE-COURSE KNOWLEDGE ASSESSMENT ____POST-COURSE KNOWLEDGE ASSESSMENT

PART I: BASIC CONCEPTS

1. Give two examples of nonverbal communication. The first is an example that contributes to positive, effective communication; the second is an example that is negative or contributes to ineffective communication.

   Example 1: (positive)

   Example 2: (negative)

2. Give an example of an open-ended question.

3. As a TB health care provider you have a great deal of influence over the outcome of your interaction with the client. Name two techniques you can use to communicate more effectively with your clients and coworkers.

4. When you work with patients, contacts, and other clients and with coworkers, you want to be persuasive, influential and effective. Look at this continuum:

   Passive — Assertive — Aggressive

   Place an "X" where you would like your communication style to be characterized. Define this style, and describe why you think it is most effective.

5. Briefly describe a situation where you could use confrontation as an effective strategy for problem solving with a recalcitrant client.

6. List three factors that influence patient compliance with tuberculosis treatment.

7. List three strategies that you can implement that would positively influence your client's compliance behavior.

PART II: INTERVIEWING

1. List three steps that you can take, or do take, to increase your effectiveness when interviewing patients.

2. Describe in a few sentences how you introduce the purpose of the initial interview with patients.

3. How would you, or do you, plan for resistance from the patient during an interview?

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PART III: FIELD INVESTIGATION

1. A great deal of information is exchanged during field investigations. Name at least two major outcomes that you should achieve with a client during a field investigation.

2. Name two resources that you might use, or do use, to verify the address location of clients you need to contact in the field.

3. You have just arrived at the residence of a nonfamily contact of a newly diagnosed smear positive case of tuberculosis. Using the direct approach, you explain to the contact why you are there and what he/she should do. The contact then says to you "Do I have tuberculosis?" What do you say back to the contact?

4. The clinic supervisor gives you the name and address of a noncompliant patient and asks you to refer the patient to the clinic so that directly observed therapy can be started. When you arrive at the address, you find that the patient does not live there. What should you do?

Division of Tuberculosis Control
Center for Prevention Services
Centers for Disease Control

INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL

PARTICIPANT'S COURSE KNOWLEDGE ASSESSMENT RATING SHEET

Participant's Name: ______________________________

Participant's SS#: ______________________________

Dates of Course: ______________________________

Location of Course: ______________________________

Instructor(s) ______________________________

____

Check the parts of this course that you completed:

Part I	Basic Concepts	_______
Part II	Interviewing	_______
Part III	Field Investigation	_______

Pre-course Knowledge Assessment Score (# correct): __________

Post-course Knowledge Assessment Score: __________

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Division of Tuberculosis Control
Center for Prevention Services
Centers for Disease Control

INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL

PARTICIPANT'S COURSE FEEDBACK FORM

Instructor(s)______________________________ Dates________ Location____________________

A. SUBJECT CONTENT	TOO MUCH	BALANCED	NOT ENOUGH
1. Theoretical	☐	☐	☐
2. Practical	☐	☐	☐

B. SUBJECT LEVEL	TOO ELEMENTARY	JUST RIGHT	TOO ADVANCED
	☐	☐	☐

C. PRESENTATIONS	EFFECTIVE	SOMEWHAT EFFECTIVE	NOT EFFECTIVE
1. Ability to Communicate	☐	☐	☐
2. Emphasis of Key Points	☐	☐	☐
3. Visual Aids	☐	☐	☐
4. Handout Material	☐	☐	☐
5. Role Plays/Discussions	☐	☐	☐

D. PLEASE RECORD YOUR OVERALL REACTIONS TO THE INSTRUCTOR(S) BY PLACING AN "X" IN IN THE APPROPRIATE BOX ON THE SCALE.

Excellent					Good					Fair					Poor				
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20	19	18	17	16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1

E. YOUR SUGGESTIONS FOR IMPROVING THIS COURSE WOULD BE APPRECIATED

____
____
____

F. OTHER COMMENTS

____
____
____

DHHS:PHS:CDC:CPS:DTBC:9/87

Instructor's Report

Dear Instructor:

Congratulations on having completed teaching INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL. Your comments and suggestions are welcome and will be very helpful to us. Please complete the Instructor's Report of Training Course form and mail it within 10 days to:

Program Services Branch
Division of Tuberculosis Control
Center for Prevention Services
Centers for Disease Control
Atlanta, Georgia 30333

It is not necessary to submit the participants' individual assessments and feedback forms, but you should use them to provide information which is requested on the Instructor's Report.

Thank you for using our course.

Dixie E. Snider Jr.
Dixie E. Snider, Jr., M.D., M.P.H.
Director
Division of Tuberculosis Control
Center for Prevention Services
Centers for Disease Control

DHHS:PHS:CDC:CPS:DTBC:9/87

Division of Tuberculosis Control
Center for Prevention Services
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INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL

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Number of participants: __________

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How can the course be improved?

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Participant Guide

INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL

PARTICIPANT GUIDE

Department of Health and Human Services
Public Health Service
Centers for Disease Control
Center for Prevention Services
Division of Tuberculosis Control
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PARTICIPANT GUIDE

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FOREWORD

INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL was developed by the Division of Tuberculosis Control, Center for Prevention Services, Centers for Disease Control (CDC). The purpose of the course is to improve the knowledge and job skills of health department staff who have tuberculosis interviewing, investigating, and complience influencing responsibilities. It should be considered as only one part of your training and development. Since you and your classmates may belong to various personnel classifications, we use "TB health care providers" throughout the materials to designate persons who work with tuberculosis clients.

Interviews, investigations, and compliance influencing strategies are vital components of the tuberculosis control program. Activities of TB health care providers are directed primarily toward cases, suspects, contacts, and persons on preventive therapy. These persons are referred to as "TB clients" in the course.

The course is divided into three parts so that your instructor may target your specific training needs. "Part I, Basic Concepts," contains preparatory material, such as principles of communication and assertiveness, which is essential for both of the other parts. "Part II, Interviewing," deals with the skills of interviewing patients and suspects. "Part III, Field Investigation," focuses on outreach activities in the community. If your job responsibilities include interviewing and field work, your instructor may want you to take the entire course. If your work primarily involves interviewing patients and suspects, you may be scheduled to take only Parts I and II. If you work in the field most of the time, you may be scheduled for Parts I and III. Your instructor will have done a careful assessment of your job functions and current skill levels in order to meet your unique training needs with this course.

The three parts of the course are divided into component sessions. Each session is important to your learning new or improved techniques for interviewing, conducting field investigations, and influencing compliance. The sessions are reflected on the agenda which you will receive in class as well as in the material provided in this Participant Guide. Each of the sessions has specific objectives to guide you. Become familiar with the objectives before attending the session to which they relate. You will be given two tests: a Pre-course Knowledge Assessment and a Post-course Knowledge Assessment which will enable you and your instructor to measure your increased knowledge.

Your Participant Guide is the primary text for the course. Review it carefully and bring it to class every day. The Guide gives you information for each session, such as the objectives, suggested readings, and background information about the subject matter. The NOTES portion for each session may be used to write down your questions and comments about the reading material or the notes your take in class. Additional note paper will be provided by your instructor. Handouts you receive during class should be inserted in the appropriate sections. Upon completing the course, the Participant Guide will be useful as a convenient reference manual.

Several teaching techniques are combined in this course. Classes will include presentations by your instructor, role playing exercises, group discussions, practice interviews, and videotaping and playback sessions. Required outside readings and other homework assignments are integral to the course. To get the most out of the course, complete the readings prior to the classroom sessions, and attend class fully prepared to participate in all phases of the learning process.

Interviews, investigations, and compliance influencing efforts mutually support the success of each other. For example, a case or suspect's information about contacts is of no value if your investigations and referrals fail to assure that they are examined. Likewise, the value of your investigative skill is limited if contact information you obtain from the patient is vague, inadequate, incomplete, or poorly analyzed. Directly observed therapy as a strategy for assuring compliance is ineffective if you cannot locate the patient on days when medicine is to be ingested.

Each interview, investigation, and compliance influencing activity has a specific role in the control of tuberculosis and requires the competent application of a variety of skills. You must master these skills in order for program goals and your own performance goals to be achieved. You will be introduced to these skills in this training course. The word "introduced" is stressed, because these are skills that can be mastered only through time and experience. The skills necessary for successful interviews and investigations can be best developed "on the job" with the support of coworkers and supervisors. This course, however, provides you some of the fundamentals of interviewing, investigating, and influencing compliance. It also reviews the types of situations which you encounter from day to day and presents some of the basic principles that are common to them.

At the conclusion of the course, you will be given the opportunity to give your instructor comments and suggestions about the course. Evaluations from the field will be very helpful in improving the course and will assist us in our efforts to meet current and future needs for assistance in training tuberculosis control staff.

Best wishes for a pleasant and productive learning experience!

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OVERVIEW OF PART I: BASIC CONCEPTS

"Part I, Basic Concepts," is the foundation for INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL. It gives you an opportunity to practice communication skills that are the basis for good interviewing, investigating, and influencing techniques. Through practice and feedback, you will focus on verbal and nonverbal communication skills, listening skills, open-ended questions, assertiveness skills, compliance influencing strategies, and problem solving techniques. Much of your skill development will occur during role playing exercises. Class time will be dedicated in each session to discussion and relating the course content to the day-to-day problems and issues that you face.

NOTES

PRINCIPLES OF COMMUNICATION

OBJECTIVE

Participants will be able to put effective communication techniques, particularly those designed to improve patient compliance with desired behaviors, into practice.

SUGGESTED READING

Hanks K. How to motivate others to do what you want and thank you for the opportunity. Argus Communications, 1982.

Nirenberg J. How to sell your ideas. McGraw-Hill, 1984.

Communication is a process whereby individuals share something of themselves, e.g., ideas, opinions, values, goals, and feelings, with others. The process involves sending and receiving messages. These messages can be generally thought of as information. Any information that is shared between two or more individuals is shared through the communication process.

In every communication, at least two persons are involved. They are the sender and the receiver. The sender is the person from whom the message originates. The receiver is the person who reads or hears the message.

There are two basic forms of communication: written and oral.

Written communication involves putting messages on paper or in some other form so they can be read by others. We are going to concentrate on oral communication. Oral communication is an interactive process which involves two or more people. One person is the sender, and another person is the receiver. Frequently, each person is a sender and a receiver, and in many interactions there are multiple senders and receivers.

There are several actions that take place in every oral communication:

One person (the sender) initiates a message.

Another person (the receiver) listens to and observes the sender.

The receiver receives and decodes the message.

The receiver gives feedback (responds) to the sender.

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The effectiveness of a person's oral communication depends to a large extent on the sender's ability to define the purpose of the interaction and to display self-confidence in the worth of the information that is being sent. However, the entire responsibility for effective communication does not rest with the sender. In fact, effective communication depends not so much on talking as it does on listening. The listener has perhaps the greater role and responsibility in the communication process.

There are two distinct kinds of messages which are involved in oral communication. They are verbal and nonverbal messages.

Verbal messages are simply the words, formed into phrases and sentences, that are spoken by one person and listened to by another. "You deserve a break today," "Jake has gone shopping," and "I love you" are examples of verbal messages sent from one person to another.

Nonverbal messages are the unspoken messages. They are present in every communication just as as surely as the spoken words are. Another term for nonverbal messages is body language. Nonverbal messages are transmitted by a sender to a receiver in every communication interaction. The first message the receiver gets from the sender is a nonverbal one. The receiver's first, and perhaps lasting, impression of the sender is based on that initial nonverbal message. In every interaction, the nonverbal messages that are sent during the exchange are the "music to which the words are set." For communication to be effective, it is important that positive, not negative, nonverbal messages be sent. Characteristics such as eye contact, facial responses, posture, body orientation, and distance determine whether the nonverbal message is positive or negative.

Verbal messages are either positive or negative, too. "You look marvelous" and "What cyclone tossed you around?" are examples. Not only do the words themselves convey a positive or negative message, but the manner in which the message is sent is a determining factor. The length of the message, organization of thoughts, specificity, and diction qualities of the sender are important aspects of the communication process.

To effectively communicate with others, how we listen is much more important than how we talk. Effective communicators ask questions. They draw the other person out. They ask for examples. They focus the conversation on the other person, and then they stop talking and listen.

Interviewing, investigating, and influencing compliance in tuberculosis control involve communication between TB health care providers and clients. If we communicate effectively with clients, we can increase the effectiveness of interviews, investigations, and actions to influence compliance.

NOTES

CHARACTERISTICS OF NONVERBAL COMMUNICATION

EYE CONTACT

FACIAL RESPONSES

POSTURE

BODY ORIENTATION

DISTANCE

PRINCIPLES OF VERBAL COMMUNICATION

BE BRIEF

BE ORGANIZED

BE ENTHUSIASTIC

REPEAT YOURSELF

BE SPECIFIC

PRINCIPLES OF LISTENING

LISTEN WITH YOUR WHOLE SELF

REPEAT AND REPHRASE WHAT YOU HEAR

DEVELOP SENSITIVITY FOR WHAT IS LEFT UNSAID

MAKE USE OF THE THOUGHT-SPEED/SPEECH-SPEED RATIO

ASSERTIVENESS

OBJECTIVE

Participants will be able to respond assertively and thus will become more effective communicators with clients and coworkers.

SUGGESTED READING

Fensterhem. Don't say yes when you want to say no. New York: Dell Publishing Co., Inc. 1975.

Galassi and Galassi. Assert yourself. New York: Human Sciences Press. 1977.

Assertive, aggressive, and nonassertive. These terms are used most often to describe how we relate to other people and how they relate to us. Assertiveness, aggressiveness, and nonassertiveness are behaviors which we employ in relationships. How we behave toward others - whether we tend to be primarily assertive, aggressive, or nonassertive - has connections to the total make-up of our individual personalities. We are not born aggressive, assertive, or nonassertive. We learn these behaviors.

Each of these behaviors produces specific responses in both the individual who displays the behavior and the individual toward whom the behavior is directed. Aggressiveness and nonassertiveness are associated with negative reactions. Assertiveness is associated with positive reactions. The effectiveness of our interactions with others is determined by which one of these three behaviors is employed in the relationship. Aggressiveness and nonassertiveness can result in failed relationships, because these behaviors promote negative reactions. Assertiveness, on the other hand, produces positive responses, and thus gives us an edge in establishing and maintaining effective relationships with other people.

Being assertive is a asset in interactions with others. Assertiveness is not insisting, arguing, or demanding something of another person. Instead, it is a sense of believing in oneself and the act of executing that belief in a manner which shows respect for the other person. It is associated with one's presenting oneself well, being actively involved, practicing constructive work habits, giving and taking criticism and help, controlling fear and anxiety, and being satisfied with performance. Assertiveness is a way of relating to others on the basis of mutual respect.

The assertiveness formula is:

R + R + S = A

R = Respect for others
R = Respect for oneself
S = Specificity in communication
A = Assertiveness

Assertiveness comes from believing in oneself and in the activity that is undertaken. It is the act of executing those beliefs in a manner which does not compromise the rights or beliefs of either party in the relationship. Assertive people are self-confident and have respect for others. When people behave nonassertively, they either do not believe in the activity or are compromising their rights or beliefs. When people behave aggressively, they are compromising the rights others. Aggressiveness and nonassertiveness in interactions with another person create obstacles to cooperation with that person.

The various responsibilities of TB health care providers often place us in situations which require assertive responses. Many of the situations we enter with clients test our self-confidence and commitment to our mission and purpose. At these times, our professional qualities can be put to the test. The way we handle these situations - assertively, aggressively, or nonassertively - more often than not determines the effectiveness of the interaction and the outcome of the activity we are engaged in with the client.

NOTES

NONASSERTIVENESS:	To give up one's rights and/or position to others.
AGGRESSIVENESS:	To demand one's rights and/or position at the expense of others.
ASSERTIVENESS:	To claim and maintain one's rights and/or position without compromising the rights of others.

THE ASSERTIVE APPROACH

PERSONAL SELF-CONFIDENCE

UNDERSTANDING THE PURPOSE AND VALUE OF THE INTERACTION

BELIEF IN THE INTERACTION

INTRODUCTION TO INTERVIEWING

OBJECTIVE

Participants will be able to ask open-ended questions.

NOTE

An introduction to interviewing is presented in Part I so that health care providers who are not responsible for "formal" interviews can learn some of the basic principles of interviewing which are also applicable to field activities. The techniques of asking questions covered in this session are just as important to persons who do field work as they are to those who actually conduct interviews with patients.

The effectiveness of relationships is dependent upon a mature and positive interaction between individuals. As TB health care providers, we have a responsibility to establish and maintain effective relationships with clients. Indeed, the success of tuberculosis control activities is directly linked to our individual relationships with the clients we serve. Program successes are realized to the degree we are successful with each of our clients. We have considered the importance of practicing the principles of communication and assertiveness skills. How else can we work toward achieving positive relationships with our clients?

A major vehicle through which we communicate with and relate to the client is the interview. The interview is a a "structured" mechanism for health care providers to interact with clients. A tuberculosis interview is an individualized exchange of information. Information is shared. The information flow is two way, i.e., information is given and received by both the health care provider and the client. Interview information, both verbal and nonverbal, is the basis for diagnosis, treatment, followup, contact investigation, and prevention. Good interviews will elicit from the patient the necessary history, personal data, reaction to and knowledge of tuberculosis, names of contacts, and other information which we need to ensure that the patient and contacts receive the services they need. Good interviews also educate the patient about the disease and promote compliance with treatment recommendations. The interview focuses on assuring that the patient becomes non-infectious, complies with treatment and followup recommendations, and identifies contacts for examination and preventive treatment. Application of the principles and techniques of interviewing, especially asking questions in the correct way, is a powerful way to build and maintain positive interactions with clients and with other persons in the field.

There are two types of questions we are inclined to use most of the time: open-ended questions and close-ended questions. Close-ended questions,

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although polite and acceptable in social relationships, do not promote a dialogue and therefore are not usually appropriate in an interview. Close-ended questions can be answered by a "yes" or "no" response, and unless the respondent wants to engage in further conversation, the interaction can end with the "yes" or "no" response. An extensive information exchange is what is required in a tuberculosis interview. Close-ended questions do not promote a dialogue, and therefore, they have a negative effect on the interview and the emerging relationship with the client. Furthermore, the use of close-ended questions in an interview is an invitation for the interviewee - not the interviewer - to take control. When this happens, our chances for success with the client and related contributions to program success are in jeopardy. Open-ended questions do promote a dialogue and virtually guarantee that we will obtain complete and accurate information from clients. Open-ended questions strengthen the odds for our building and maintaining the effective relationships we need to have with individual clients.

NOTES

PROBLEM SOLVING

OBJECTIVE

Participants will be able to apply the basic problem solving steps.

Although the we may apply the principles of communication, put our assertiveness skills to work, ask questions in the correct way, and take other measures to establish and maintain productive relationships, some clients have unique needs and present challenges which require special attention on our part. For example, some patients are uncooperative in identifying contacts in the interview. Some become noncompliant in taking medications and following instructions to submit sputum specimens. Others fail to keep clinic appointments for followup examinations. We generally label these kinds of situations as "problems." The client is not a problem, but the circumstance resulting from the client's attitude or behavior is. We encounter problems routinely in our interactions with clients. They emerge in almost every health care provider/client relationship. When problems arise, it is our responsibility to deal with them. Otherwise, the interaction becomes ineffective, and the result for the patient and the program is not good. Dealing with problems has but one purpose: to solve the problems.

Just what do we mean when we say something is a "problem"? We mean that something is not right, not the way it should be. A problem may be defined as a deviation between what should be happening and what is actually happening. Stated another way, a problem is a deviation between the "expected" and the "actual" of a particular situation. If you expect your car to get 30 miles per gallon of gasoline (because it has averaged getting 30 miles per gallon since you bought it a year ago), but now it is only getting 19 miles per gallon, you have pinpointed a problem. There is a deviation between what should be (the "expected," i.e., 30 mpg) and what is happening (the "actual," i.e., 19 mpg). If a patient on directly observed therapy does not meet you at the designated time and place to take medicine, there is a problem. If a contact you refer to the clinic for a tuberculin skin test fails to come, there is a problem. If a patient you are interviewing does not want to answer the questions you ask in order to structure the contact investigation, there is a problem. These clients need special assistance from you so that the deviation between what should be and what is happening can be eliminated. It is your responsibility to recognize, diagnose, and then collaborate with the client to solve the problem(s).

The goal of any interaction between a health care provider and a client is to achieve health-related objectives that benefit the client as well the community. Achievement of the goal is always related to an on-going assessment of the client and the client's needs. Your success in recognizing and solving problems that present obstacles to achieving the goal is directly related to practicing good communication skills, especially listening techniques, and to responding individually to each client in an assertive manner.

Problem solving involves identifying the symptoms, diagnosing the problem, and implementing a solution. Problem symptoms can surface at any time in any interaction with a client. The symptoms have to be evaluated; the interaction must be refined so as to get more information on which to base an evaluation. Information is best obtained by the use of open-ended questions. Diagnosing the problem requires that you listen and look for the symptoms, ask the client pertinent questions, and analyze the feedback. Once a problem is diagnosed, the process of problem solving can begin.

The problem solving process is your response to the deviation between what "should be" and what "is". One way of responding is by confronting the deviation with the client. Confrontation as a problem solving methodology is a challenge to the client to examine or change some particular aspect of his or her behavior. Confrontation must always be followed by appropriately tailored motivations for the client to work with you toward achieving a common goal.

A client will often be motivated to change a behavior, comply with your instructions, or otherwise cooperate, for one of three basic reasons:

- The client feels it is beneficial to him/her.

- The client feels it is beneficial to others, e.g., family members, friends, coworkers.

- The client feels obligated to do what is asked because of respect for you or the health care system.

The client has certain perceptions of the situation and plans for how to deal with it. The client will retain those perceptions and plans unless motivated to make a change.

Careful listening, open-ended questions, and analysis provide the best approaches to problem solving by confrontation. Until the client believes that the consequences of not cooperating are greater than the consequences of what you are asking, he/she is likely not to comply. Problem solving must be developed as interactions with a client progress. The process must begin immediately when a potential problem is identified. Conflicting facts or observations must be confronted. Problems must be solved before you and the client can work successfully toward accomplishing a mutual goal. Clients will most often be motivated by appropriate confrontation and positive reinforcement.

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PROBLEM SOLVING STEPS

IDENTIFY THE SYMPTOMS

DIAGNOSE THE PROBLEM

IMPLEMENT THE SOLUTION

A PROBLEM SOLVING MODEL

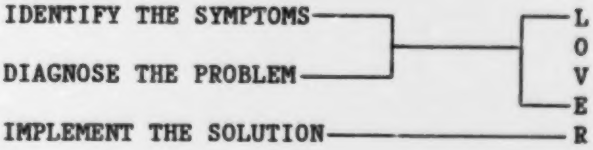
L = LISTEN

O = OBSERVE

V = VERIFY

E = EVALUATE

R = RESPOND


IDENTIFY THE SYMPTOMS
DIAGNOSE THE PROBLEM
IMPLEMENT THE SOLUTION
L
O
V
E
R

CONFRONTATION

Confrontation occurs when one person challenges another person to examine or change some particular aspect of his/her behavior.

FORMS OF CONFRONTATION

PRESENT INFORMATION

PROMOTE SELF-INVOLVEMENT

SUGGEST WITHDRAWAL OF REINFORCEMENT

COMPLIANCE

OBJECTIVE

Participants will be able to describe the strategies for improving patient compliance.

REQUIRED READING

Snider DE, Hutton MD. Improving patient compliance in tuberculosis treatment programs. DHHS, PHS,CDC. 1986.

NOTES

IMPROVING PATIENT COMPLIANCE IN TUBERCULOSIS TREATMENT PROGRAMS

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PREFACE

In recent years, there has been an increasing awareness of, and concern about, the problem of noncompliance with prescribed antituberculosis chemotherapy. This booklet provides a brief overview of what is known about compliance and offers suggestions for detecting and dealing with noncompliant behavior as it relates to treatment of tuberculosis and preventive therapy for tuberculous infection.

Some of the material presented was derived from an excellent book edited by Haynes, Taylor, and Sackett entitled "Compliance and Health Care" which readers may wish to consult for a more detailed and thorough review of the subject. Some of the suggestions for improving compliance are taken from published research studies; others are provided solely upon the recommendation of successful TB control workers around the country. We thank all of those who contributed their ideas and experiences during the initial writing and subsequent revisions of this booklet.

DHHS:PHS:CDC:CPS:DTBC:2/86

OVERVIEW AND MAGNITUDE OF THE PROBLEM OF NONCOMPLIANCE

In the past, physicians were taught that the limit of their responsibility was to diagnose and prescribe appropriate treatment for a disease. The patient was expected to assume responsibility for complying with the physician's advice. According to this view, if the patient failed to comply, he/she simply reaped the consequences (by not getting better, getting worse, dying, or if he/she had a communicable disease, being quarantined) of this "noncompliant" behavior. Today, many health care providers are approaching the issue of compliance from a fresh viewpoint: All of us selectively choose what we wish to do and wish not to do; generally, we tend to be more "compliant" with the health care provider's prescription if we (1) perceive it is important, (2) feel capable of performing the task, (3) perceive benefits from performing the task, and (4) can easily assimilate the task into our daily lifestyle. With this viewpoint, the responsibility for dealing with the problem of noncompliance is not seen as belonging solely to the patient. The effective health care provider must share that responsibility by: (1) Assuring that the patient has the knowledge and skills necessary for compliant behavior; (2) maintaining an awareness of the "signs and symptoms" of noncompliance; and (3) helping the patient identify and remove obstacles to compliant behavior. When the disease is an infectious one, such as tuberculosis, the problem of noncompliance takes on an added dimension. Public health officials must understand and address the issue of compliance in order to assure that infectious cases of tuberculosis are brought under treatment and rendered noninfectious for the protection of others in the community.

Compliance is defined as the extent to which a person's health-related behaviors, i.e., taking medication, keeping appointments, etc., coincide with medical advice. Those who object to the term "compliance" because of its judgmental connotation, may wish to substitute the word "adherence" wherever "compliance" appears. Both terms are intended to be nonjudgmental; that is, there is no implication of blame.

Noncompliance is a protean feature of all self-administered therapeutic regimens, regardless of the medical condition(s) for which they are prescribed. Scheduled appointments that are initiated by health care providers are kept about 50 percent of the time. Compliance with medication prescribed over many weeks or months (as is the case with antituberculosis drugs) also averages about 50 percent.

It has been repeatedly confirmed that noncompliance is a major cause of relapse in tuberculosis. Reports submitted to the Division of Tuberculosis Control, Centers for Disease Control (CDC), by tuberculosis control programs throughout the United States indicate that about 20 percent of tuberculosis patients fail to complete therapy within a 24-month period. In some programs, the figure is as high as 50 percent.

Compliance with preventive therapy is also a problem. According to program reports submitted to CDC, 20 to 25 percent of the persons prescribed preventive therapy in the United States fail to complete treatment within 1 year. In an isoniazid (INH)-related hepatitis surveillance program conducted during the early 1970's, patients were prescribed the usual 12-month course of INH. About 64 percent of them picked up 3 consecutive monthly supplies of

INH, 41 percent picked up 6 consecutive monthly supplies, but only 22 percent picked up all 12 consecutive monthly supplies. Thus, data from several sources indicate that noncompliance is a major problem in tuberculosis control.

PREDICTING COMPLIANCE

Traditionally, health care providers have attempted to predict compliance based on subjective judgements of personality traits and behaviors. This approach is not very reliable. More objective tests, such as the Minnesota Multiphasic Personality Inventory, may be helpful, but are not very practical to apply in the clinic setting.

While it may be true that alcoholics are more likely to be noncompliant, our experience in using the brief Michigan Alcoholism Screening Test to predict noncompliance has been disappointing.

Recent research suggests that brief questionnaires based on the belief intention model may be useful for predicting compliance with antihypertension medication (See references 26 and 38). One study of a small group of adolescent girls indicated that a four-point self-assessment of past compliance with medications and a self-rating according to well-organized -- forgetful personality traits proved helpful in predicting compliance with contraceptive medications (See reference 36). Unfortunately, a questionnaire for tuberculosis patients has not been developed and tested.

MEASUREMENT OF COMPLIANCE

The value of estimates of an individual patient's level of compliance depend to some extent upon the specific behavior being measured, how it is measured, and how frequently it is measured. There are two basic methods of measuring compliance with medication taking: Direct and indirect.

Direct methods

Direct methods consist of the measurement of blood levels and/or urine levels of drugs and their metabolites. Blood levels can be determined by special arrangement in only a few selected laboratories (e.g., the National Jewish Center for Immunology and Respiratory Medicine or the Centers for Disease Control) and, hence, are not commonly used to measure compliance.

Several simple methods for testing urine for the presence of major antituberculosis drugs or their metabolites have been published (see Appendix) and a simple dipstick method for detecting INH metabolites in the urine is commercially available. Although some of these methods have been available for several years, they have been underutilized by most health care providers.

When testing urine or blood specimens, it is important to carry out the test at the right time. Information about the appropriate timing of tests is given in the Appendix.

Indirect methods

The following indirect methods of estimating compliance have been tried:

Response to therapy

The response of the patient to therapy can be ascertained by answering these questions: Did the sputum convert to negative? Did the chest film improve? Did the signs and symptoms disappear? This would appear to be a sensible, "bottom-line" approach to the detection of noncompliance, but using response to therapy as the sole method of assessing compliance is unsatisfactory for several reasons. First, several weeks or months may elapse between the initiation of therapy and the discovery that sputum conversion has not occurred or that the X-ray did not improve. In the meantime, transmission of infection may continue, drug-resistant organisms may emerge, or the patient may develop complications or die. Second, factors other than noncompliance, such as drug resistance, can lead to a poor therapeutic outcome. Third, a noncompliant patient may take enough drug(s) to become culture negative, but not enough to prevent treatment failure or relapse several weeks or months later. With respect to preventive therapy, this method is unsatisfactory for assessing compliance because "failure to respond," i.e., the development of tuberculosis, may not be detectable for decades.

Interview technique

A second indirect measure of compliance is the interview technique, i.e., the patient is asked, in a nonthreatening manner, whether he or she has missed taking any of the prescribed doses of medication. For example, the following question might be asked: "Many people have trouble remembering to take their medication every day; since your last visit, how many days have you forgotten to take yours?" Although many patients may deny noncompliant behavior, approximately one half of the noncompliant patients can be detected in this way.

Keeping appointments, refilling prescriptions, and pill counts

These are easy ways to detect noncompliance, but patients who keep appointments and obtain refills of prescriptions don't necessarily take their medication. Pill counts done during a home visit are of more value, but some patients may discard pills rather than swallow them.

Medication monitors

A fourth indirect method utilizes medication monitors, i.e., special packaging devices which can detect whether or not medication is removed at appropriate time intervals. However, their usefulness has not been adequately assessed in appropriately designed experiments. Furthermore, because medication monitors are not commercially available, this method cannot be routinely utilized at the present time.

Judgment of the provider

A final indirect method, the one most frequently utilized, is the health care provider's subjective assessment of compliance. Studies have shown, however, that physicians and other health care providers are very unreliable in assessing patient compliance.

DETERMINANTS OF COMPLIANCE

There are many factors which are known to affect compliance behavior:

Features of the referral process

The longer the interval between the time of referral and the time of appointment, the less likely it is that the patient will keep the appointment. Referral to see a specific provider, rather than referral to a clinic, enhances compliance, provided it does not increase waiting time.

Features of the clinical setting

Waiting time has an important effect on compliance rates. The longer the waiting time in a clinic, the higher the "no-show" rate on subsequent appointments. Although individual appointment times usually increase compliance, they may decrease compliance if the waiting time is prolonged. Other features of the clinical setting such as hours of clinic operation, distance from the patient's home, availability of snacks and coffee, cleanliness, etc., have not been well studied. It seems logical to assume, however, that a clean, easily accessible clinic with convenient hours of operation would be conducive to more compliant behavior. Research has shown that we are fonder of the people and things we experience while eating. Therefore, the provision of snacks and beverages to patients in the clinic has a rational basis.

Features of the regimen

Duration of treatment

The duration of treatment has an unequivocal effect on compliance. In general, adherence to treatment decreases with time. This is one consideration which has led to the study and recommended use of short-course chemotherapy regimens.

It is prudent not to tell the patient what the exact duration of treatment will be until drug susceptibility tests results and sputum conversion times are known since these factors will influence the decision. Tell the patient treatment might need to be as long as 18 months, but if he/she takes the medicine as prescribed and responds well, the duration of treatment might be much shorter.

Number of medications prescribed

Another factor of some importance is the number of medications prescribed--the larger the number, the lower the compliance rate. This poses a problem in tuberculosis control because appropriate treatment requires that two or more drugs be prescribed. The use of the INH-rifampin (RIF) combined capsule Rifamate^R, may improve compliance.

Frequency of dosing

Although not proven by controlled studies, it is probably important to simplify the regimen so that drugs are taken only once daily. In most tuberculosis treatment programs this is routine prescribing practice. The effect of prescribing self-administered therapy on a less-than-daily basis (e.g., twice-weekly) has not been studied in a controlled fashion, but Stead and Dutt have had good results with this approach in Arkansas.

Prescription labeling

Obviously ambiguous or unclear instructions on the prescription label may lead to poor compliance. Therefore, these instructions should be carefully, but concisely, worded.

Side effects

Although it seems logical that compliance might be adversely affected by drug side effects. Most studies have not shown this to be an important determinate for compliance. Patients should, however, be urged to report any suspected side effects to the health care provider.

Cost

The relationship between the cost of medications to the patient and compliance has not been carefully evaluated, but cost is probably a barrier. Today, most tuberculosis control programs offer drugs free of charge so that this potential barrier has been removed.

Safety-lock containers

Safety-lock ("child-proof") containers interfere with the compliance of some patients, particularly the elderly, arthritis sufferers, etc.

Parenteral medications

The use of parenteral medications, such as streptomycin (SM), often increase compliance, not only because some patient groups believe injectable drugs are better, but because of the supervision which is required (see below). Supervision of therapy obviously makes it easier to assess compliance.

Features of the patient's lifestyle

Compliance is more likely when medications are taken every day at approximately the same time. Therefore, anything that interfere's with the patient's ability to follow a regular daily schedule could constitute a barrier to compliance. Such barriers might include unpredictable work hours, frequent travel, unemployment, excessive use of drugs or alcohol, and lack of an income sufficient to meet basic needs. More research is needed in the effects of these factors on compliance.

Social support

There is evidence that patients who receive support from family and/or friends are more likely to comply. Those without such support may benefit from interactions with other patients (e.g., the so-called "breakfast clubs" in Fresno and Atlanta, soup kitchen in San Francisco, clubs in Baltimore), or from more prolonged intimate contacts with supportive and friendly clinic staff.

Health beliefs

During the 1950's, Dr. Godfrey Hochbaum and his associates in the U.S. Public Health Service, developed a theoretical framework for explaining the likelihood of an individual's undertaking a preventive health action, e.g., participating in a mass chest X-ray screening program to detect tuberculosis. This theory, usually called the Health Belief Model, states that an individual's adherence to a recommended health action is dependent upon his perception of: (1) His own susceptibility to the disease, (2) the seriousness of the disease; (3) the benefits of the health action; and (4) the barriers of taking the action. This theory has been the focus of several studies which suggest that, instead of preceding and determining compliant behavior, health beliefs develop along with compliance behavior as a result of the experience gained by patients during the early weeks or months of therapy. These findings suggest that the quality of the patient-provider interaction is important, especially during the early phase of therapy.

Locus of control

Research findings suggest that persons who feel they are in control of their own life are more likely to comply than persons who feel their life is controlled by external forces.

Features of the patient-health care provider interaction

Although the quality of this interaction is very important, it is difficult to objectively assess, describe, and teach. The desired outcome is obvious, however. Through this interaction, the patient should develop confidence in the health care provider and be motivated to comply.

Sir William Osler has been quoted as saying, "The art of patient care is in caring for the patient." This statement summarizes that attitude which best fosters a good patient relationship. Staff members who don't "care for their patients," but rather see patients as inferior, unworthy, ignorant, or a bother to take time with, cannot help but foster noncompliance. Despite what such staff may believe, they cannot avoid unconsciously communicating these feelings to their patients.

Marketing research has shown that people are more inclined to say yes to those they know and like. Furthermore, people tend to like those they perceive as being similar to them, i.e., of the same race/ethnic group, the same or a similar occupation, the same socioeconomic status, etc. Different patients may relate best to different persons on the staff and each staff member has the potential for playing an important role in enhancing the patient's compliance and chances for cure.

Demographic features of the patient

Patient characteristics such as age, sex, education, socioeconomic status, occupation, income, etc., have not consistently been shown to be associated with compliance. These factors do have an effect on access to health services, however.

Features of the disease

Factors associated with the disease process, such as severity and number of symptoms are generally unimportant as determinants of compliance, although the degree of disability tends to influence compliance in a positive direction, i.e., the more disabled the patient is by the disease, the greater the likelihood of compliance.

STRATEGIES FOR IMPROVING COMPLIANCE

Effective strategies for improving the compliance of an individual patient are those that remove the specific barriers to compliance that are experienced by that individual. Thus, for the health care provider, possessing an understanding of the difficulties associated with behavior change and taking time to get to know the patient are essential.

Even though no perfect solution to the problem of noncompliance has been found, some proven strategies can be used to set the stage for enhanced compliance as well as to deal with problems when they do emerge (and in some situations, before problems emerge).

Patient education

In order to comply, the patient must first know what is expected of him or her. The health care provider must take the time to explain to the patient, in simple language, the specific compliance behaviors expected. The provider should also explain the basis for the diagnosis and the prognosis so that the patient understands the importance of complying with the medical advice. An interpreter will be required to communicate with those patients whose native language is not spoken by the health care provider. Whenever possible, clinics should be staffed with persons who can speak the language of their clients.

The amount of information which can be retained by a patient in one sitting is limited. Therefore, it is important for the provider to be organized, selective, and concise in talking to patients. Medical information first presented to the patient is more easily recalled than material presented later. It is best to outline the specific behaviors expected of the patient before explaining the basis for the diagnosis and the prognosis. The interaction with the patient should always be "two-way communication," i.e., the health care provider should elicit feedback and questions from the patient to assure that the message sent was received and understood. Because of the limitations in recall of oral communication, it is highly desirable to provide patients with written instructions. Written repetition of important material presented orally increases retention. It is important to gear the written material to the reading level of the intended audience. Merely providing patients with information, however, will not solve all compliance problems. Other strategies must be used to resolve specific compliance problems which arise.

Improving appointment-keeping

Various types of "reminders" are useful for improving appointment-keeping. A postal reminder card, mailed so that it arrives 1 or 2 days in advance of the scheduled appointment, is useful. However, telephone calls may be the best initial approach to solving the problem because they remove any doubt about whether the patient received the message or not. In addition, one can counsel patients over the telephone, and help them overcome scheduling and transportation problems and other obstacles to compliant behavior. If a clinic has a chronically low attendance rate, it is important to assess clinic operations, identify barriers to appointment-keeping, and make the necessary changes. Barriers to appointment-keeping behavior can sometimes be identified by contacting "no-shows" by telephone. Telephone or postcard reminders will not improve appointment-keeping if clinic visits are inconvenient or too time-consuming. Therefore, the provider must identify and solve these operational problems if appointment-keeping is to be improved.

Individuals who fail to keep an appointment should be contacted promptly by phone to schedule a new appointment. If the phone call fails to produce results, a home visit should be made immediately. Breaking of appointments should lead to a counseling session with the patient, designed to identify and solve problems which interfere with appointment-keeping. Repeated breaking of appointments should lead to a "case conference" attended by all members of the health care team (physicians, nurses, clerks, outreach workers, etc.) so that all pertinent information is considered and the entire staff can contribute to the solution to the problem.

Dealing with specific problems

For repeated or "chronic" compliance problems, instructions and simple reminders probably will produce only transient benefit. However, a combination of other strategies can be used to successfully identify and deal with specific problems.

Discuss the problem with the patient

Clearly state your concerns about noncompliance and its effect on therapeutic outcome to the patient. Listen to the patient's response and attempt to identify barriers to compliance which can be solved, e.g., correct misinformation, reduce side effects by "splitting" doses or giving drugs with meals, prescribe non-safety-lock containers, etc.

Problem solving should be a collaborative effort--not one in which the health care provider tells the patient how to solve the problem. No plan or intervention will be a success unless the patient helps solve the problem. The provider should facilitate the process.

If the patient comes from a cultural background which practices "nontraditional medicine," a thorough assessment of cultural barriers to the acceptance of traditional medical practices is necessary. Sometimes these patients have sought medical advice from nontraditional health care providers in their own culture. This information needs to be brought out and openly discussed.

Elicit social support

With the patient's permission, identify family members, friends, clubs, etc., who will support compliance behavior. Be sure, however, that the support person(s) is acceptable to the patient and is supportive of the provider's recommendations.

Tailor the regimen

Tailoring the regimen means simplifying and restructuring the regimen, within acceptable therapeutic limits, to coincide with the patient's lifestyle. Find a daily ritual that the patient finds pleasant and schedule medication taking just before that activity. If a reward can closely follow the taking of medication, it acts as a positive reenforcement for the behavior.

Behavior modification

Tailoring is a form of behavior modification. Other informal behavior modification methods can also be used. For example, simple verbal encouragement by members of the health care team, especially the physician, can be a very potent reenforcement when applied to ambulatory patients. For patients who lack motivation, behavioral strategies such as providing small gifts, snacks, coffee, monetary incentives, or awards for reaching therapeutic goals have often proven successful. Health departments in South Carolina and Alabama have successfully used incentives, such as food and babysitting services, to help noncompliant patients complete therapy.

The psychological principle of reciprocation suggests that doing favors for patients would enhance compliance. This principle says that we all try to repay a person who has done us a favor. By doing a patient a favor, we can legitmately ask them to do us a favor, namely take their medicine as prescribed. Such favors might include help in filling out forms, assistance in finding a place to live, providing a means of transportation to the clinic, etc.

Self-monitoring of pill consumption by checking off a calendar is sometimes useful for patients who truly forget to take their medicine.

For some patients, formalization of a written compliance agreement, "a health contract," between patient and provider works well. Instead of having the patient sign a statement someone else has prepared, ask the patient to dictate or write down in his/her own words a statement to the effect that he/she agrees to take the medicine as prescribed in return for good medical care given by the providers. This written commitment can often greatly enhance the likelihood of compliance. Furthermore, if, with the patient's permission, the clinic posts a list of patients who have made this written commitment, the likelihood of other patients' complying is likely to be enhanced.

Use extended supervision

Extended supervision, although more expensive than previously mentioned strategies, is a very effective strategy for improving compliance. It may entail: (1) Giving drugs under supervision; (2) making telephone calls and home visits; or (3) confining noncompliant patients to a hospital or other facility.

Many compliance problems can be obviated by the use of directly observed therapy. The effectiveness of this approach was demonstrated years ago, but directly observed therapy still has not been widely adopted in the United States. Such therapy can be administered daily or intermittently (e.g., twice-weekly). Intermittent regimens are generally less costly. Recommended intermittent supervised regimens include INH and RIF, INH and ethambutol (EMB), and INH and SM. All of these intermittent regimens require an initial period of daily therapy. The use of INH and RIF has the advantage of requiring a shorter total duration of therapy than the other two regimens.

Telephone calls and/or home visits to followup on broken appointments can be extremely valuable. The caller or visitor should ask about and observe for signs and symptoms indicative of treatment failure or drug toxicity. Any obstacles to compliant behavior should be discussed. During these visits, pill counts can be obtained, specimens collected for sputum smear and culture, and urine tested for the presence of drug(s) or drug metabolites. In some cases, direct administration of drugs in the home may be necessary to solve compliance problems.

As a general rule, individuals in our society have the right to refuse to follow health advice. Patients with tuberculosis, however, can sometimes be confined, by court order, to a hospital or other institution. The exercise of this "institutionalization option" (a very expensive approach to the problem) depends on the existence of appropriate laws and statutes, cooperative court and law enforcement officials, and the availability of institutional care. In many communities, one or more of these critical elements is missing. In all cases enforced institutionalization should be a solution of last resort. When enforced hospitalization is necessary, consideration should be given to the use of an "intensive" four-drug regimen (i.e., INH, RIF, SM, and pyrazinamide (PZA)) during the first 2 months of therapy. This approach will optimize the likelihood of cure, even if the patient absconds before receiving the full course of therapy.

A PRACTICAL GUIDE FOR DETECTING AND DEALING WITH NONCOMPLIANCE

Initial Compliance Assessment

Lay the groundwork for improved compliance at the time of the initial visit. Emphasize from the very first the need to take pills and continue taking them for the entire duration of prescribed therapy. Begin to collect information to assess the patient's likelihood of adhering voluntarily to the recommended therapy regimen.

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Within one week:

An assessment of potential noncompliance should be made through an interview with the patient and a home visit.

A staff member (e.g., a nurse or outreach worker) should be given responsibility for monitoring the progress of each new patient. When treatment is begun, the treatment team (this person plus the clinician, pharmacist, nursing supervisor, etc.) should discuss and agree upon a treatment and followup plan. In some cases, the probability of noncompliance will be judged high enough to justify immediately placing the patient on directly observed therapy (DOT). If the person responsible for monitoring the patient determines that the treatment plan is failing, the treatment team should develop a new plan.

Monthly Compliance Assessments

All patients should be carefully and continuously monitored for noncompliance during therapy. It is essential that a single individual on the provider "team" be assigned responsibility for ensuring that specific noncompliance assessment steps are taken throughout therapy. Suggested steps include:

Identifying missed appointments and contacting the patient immediately (this assumes that an effective system exists for keeping track of patients).

Asking patients, in a nonthreatening manner, whether or not they are taking their medication. Responsible relatives or friends may also need to be asked.

Identifying patients with a previous history of low compliance. Such patients are at high risk of repeating such behavior.

Asking patients to describe how and when they take their daily medication and comparing their response with the prescribed regimen.

Analyzing the appropriate body fluid (usually urine) for the drug or its metabolites. Simple tests for measuring levels of antituberculosis drugs and their metabolites in urine are given in the Appendix.

Conducting "surprise" and scheduled periodic home visits.

Measuring the remaining medication at each visit (pill count). Compare the amount of medication left in the bottle with the amount expected if the patients had followed the regimen exactly. Too much medication remaining indicates noncompliant behavior, but the removal of medication from the bottle does not necessarily mean compliance has been good. This method is most useful during unscheduled home visits.

Other Methods for Enhancing Voluntary Compliance

Depending on resources and the patients reliability, one or more of the following compliance improving strategies should be applied:

Pay More Attention to the Patient

Patients who miss appointments should be contacted immediately by phone or home visit. Talk to the patient about the problem. Help the patient identify and solve problems that are interfering with compliance. Communications with the patient should be in the language which the patient understands. Translator services should be available if needed.

Preappointment Reminders

Telephone patients at least 48 hours prior to their next scheduled clinic appointment to remind them of their appointment. If this is not possible, mail them a reminder.

Restructure the Regimen

Tailor the taking of medications to coincide with the performance of daily habits or rituals, e.g., having morning coffee. Simplify the treatment as much as possible. Consider using the combined INH-RIF capsule.

Elicit the Support of Family Members and Friends

Relatives or friends whom the patient respects can help with compliance problems. Avoid involving persons whose influence will be detrimental, however.

Behavioral Strategies

Feedback information to patients about their urine test results and their therapeutic responses. Positive reenforcement of compliance in the form of praise and encouragement can be quite powerful in motivating further compliant behavior. Consider giving special incentives such as small gifts or letters of praise and commendation for achievement of treatment goals. Consider a formal written compliance agreement.

Confinement of Tuberculosis Patients

Public health officials should be provided with the legal means to confine at public expense noncompliant, sputum positive tuberculosis patients who pose an infectious threat to the general community. Such confinement should be maintained until treatment is complete.

Patients with sputum positive pulmonary tuberculosis which is so drug resistant as to be refractory to treatment are potentially infectious to the general community. If cooperative, these individuals may be confined at home with close supervision by health department personnel. If uncooperative, permanent confinement should be imposed at public expense.

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Final Note

When asked for a recommendation for improving patient compliance with TB therapy, an experienced public health nurse from Arkansas said recently, "What we do is 'whatever it takes!" These words seem to summarize all the above recommendations and to embody a philosophy which no longer accepts noncompliance as inevitable and tolerable. Identifying and doing "whatever it takes" to assure completion of adequate therapy is a difficult challenge, but one that must be successfully met, if this curable and preventable disease is to be conquered.

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APPENDIX

Tests for the Detection of Antituberculosis Drugs or Their Metabolites in the Urine

Several simple, reliable, and relatively inexpensive tests for demonstrating the presence of antituberculosis drugs or their metabolites in the urine have been developed. Methods for performing a variety of tests were published in a World Health Organization technical bulletin in 1969 by Eidus and Ling (1). More recently, Burkhardt and Nel (2), and Kirsten, Armstrong, and Gatner (3) published the following methods and results of testing urine for the presence of N-acetyl INH, PZA and its metabolites, RIF and desacetyl-RIF, and EMB.

Color Test for N-Acetyl INH in Urine (1,2)

N-acetyl INH is the main metabolite of INH. It is present in the urine in larger quantities and for longer periods of time than any other INH metabolite.

The test is done in a white porcelain spot plate with hemispherical depressions which enables easy reading of results and examination of several specimens at the same time.

Reagents. Two solutions are made up and are stored separately: (1) A 10% solution of potassium cyanide (KCN), reagent grade, in distilled water; and (2) a 10% solution of chloramine-T in distilled water. The reagents may be stored in the refrigerator at 4°C in amber bottles for 1 week.

Procedure. In each plate depression the following are added in strict sequence by pasteur pipette and without shaking or stirring: (1) Four drops urine, (2) four drops 10% KCN solution, and (3) nine drops 10% chloramine-T solution. It is important that the specified number of drops be used, that the sequence is strictly adhered to, and that there is no delay between additions of each successive reagent. The method is so quick and easy that 300 urine specimens can be collected and processed in a day. Known INH-positive and -negative control urines are included in each test series to monitor the quality of the reagents.

A positive reaction is indicated by a cherry-red color of varying intensity, which develops within 1 minute. A pink color indicates that only traces of N-acetyl INH are present, and negative urine remains yellow.

The estimated cost of the test is 14 cents per 100 urine tests (2).

Burkhardt and Nel (2) reported that, after a dosage of 400 mg INH, the N-acetyl-INH metabolite could be detected after 2 hours in 96% of the urine specimens tested, after 4-6 hours in 100%, and after 8 hours in 80%. After 24 hours, none of the urine specimens were positive. Ellard and Greenfield (4) have reported a slightly more elaborate, but much more sensitive, test for INH metabolites. This procedure may eventually become the preferred test as experience with it accumulates.

A reagent-impregnated paper test strip commercially available from Difco Laboratories, is also available (5), and may be preferred by those who do these tests infrequently.

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Color Test for RIF and Desacetyl-RIF (2)

RIF and its metabolite, desacetyl-RIF, are detected in urine by the following method:

Procedure. A 10 ml urine sample is pipetted into a test tube and 2 ml n-butanol (reagent grade) is added. The liquids are mixed by inverting the tube gently twice. The tube is allowed to stand for at least 30 seconds to let the butanol separate again.

In positive urine a salmon-pink to cherry-red color appears in the upper butanol layer. A light orange color indicates the presence of only a trace of RIF and desacetyl-RIF. A false-positive result can occur if the urine sample contains an excess of urobilinogen.

The estimated cost is 68 cents per 100 urine tests (2).

Burkhardt and Nel (2) reported that 2 hours after 17 patients had ingested 450 mg of RIF, all urine specimens were positive, and they remained positive for 6-8 hours after ingestion. After a 24-hour period, RIF or its metabolites could be detected in only 25 percent of samples.

Color Test for EMB (3)

A 1 ml urine sample is placed in a 13 mm x 90 mm test tube. An equal volume of bromothymol blue solution (0.04 g bromothymol blue dissolved in 20 ml absolute alcohol; 80 ml M/15 phosphate buffer, pH 7) is added, mixed, and 3 ml of benzene are added. The test tube is sealed and the contents mixed by inversion. A distinct yellow coloration in the benzene layer denotes the presence of EMB in the urine. A standard 50 ug/ml solution of ethambutol in water provides a useful reference.

Kirsten, Armstrong, and Gatner (3) reported that 12 volunteers ingested EMB 25 mg/kg, and urine samples were taken immediately and at 2, 4, 6, 8, 10, 12, 24, and 48 hours after ingestion of the drug. Using the methods described above, no EMB was detected at 2 hours. Peak EMB concentrations were obtained at 4 hours, and in some cases, traces were still detectable 48 hours after ingestion.

In using this test, the following points must be noted: (1) Albumin rich urine may occasionally give rise to false-negative results; (2) the presence of rifampicin in the urine may obscure the test results; and (3) false-positive results may be encountered in patients who are being treated with phenothiazines.

Color Test for PZA and its Metabolites (2)

The major metabolites of PZA measured are pyrazinoic and 5-hydroxpyrazionoic acid.

Reagents. Two solutions are made up and are stored separately: (1) A 2% aqueous solution of sodium nitroprusside, and (2) a 2N solution of sodium hydroxide (NaOH 8.0 g/dl distilled water). The sodium nitroprusside reagent is stored in an amber bottle and will keep for 2 weeks in the refrigerator at 4°C.

Procedure. Before performing the urine tests, equal small aliquots (e.g., 2 ml) of each reagent are freshly mixed in a test tube, since the resultant final solution is only stable for 1 hour, after which it must be discarded.

In a white porcelain spot plate, the following are added by pasteur pipette: (1) 3 drops urine and (2) 1 drop constituted reagent. The plate is gently shaken. In the presence of PZA the bright yellow color of the solution changes to orange within 3 minutes. Known PZA-positive and -negative control urine is included in each test series to monitor the quality of the reagents.

The estimated cost of the test is approximately 1 cent per 100 urine tests (2).

Burkhardt and Nel (2) reported that after the intake of 2 g PZA, all the urine specimens tested were positive for a period of 2-8 hours; in 68% of the samples the overnight urine specimens were still positive.

Simultaneous administration of RIF and PZA (with a resultant reddish coloration of the urine due to RIF) did not interfere with the interpretation of a positive PZA reading. It is not always easy to distinguish, however, between the canary-yellow color of the negative control urine and the brick-orange of a weekly positive specimen.

Tests for Other Drugs

Methods for testing urine specimens for para-aminosalicylic acid, cycloserine, and ethionamide have been published (1) but will not be presented here.

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FACTORS RELATED TO COMPLIANCE WITH THERAPY

Referral process

Clinical setting

Duration of treatment

Number of medications

Frequency of dosing

Prescription labeling

Side effects

Cost

Safety-lock containers

Parenteral medications

Lifestyle

Social support

Health beliefs

Locus of control

Patient-health care provider interaction

STRATEGIES FOR IMPROVING COMPLIANCE

Educate the patient; explain expected compliance behaviors

Improve appointment-keeping

Confront the patient's problems

Elicit social support

Tailor the regimen

Use behavior modification

Use extended supervision

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OVERVIEW OF PART II: INTERVIEWING

Part II, Interviewing, is devoted to building tuberculosis interview skills. First, your instructor will talk about planning and structuring an interview and give you some practical steps you can take to make your interviews successful. You then will learn how to prepare an interview outline which contains the master parts of an interview. Your instructor will conduct a demonstration interview, and you will learn how to use an Interview Checklist to rate an interview and provide feedback about its strengths and weaknesses. Using realistic case studies and a Tuberculosis Interview Outline, you will practice your interviewing techniques in a dyad role playing exercise. Much of your interviewing skills development will occur during this practice session. You will then have the opportunity to put your skills into practice in a videotaping session in which each participant will conduct a simulated interview. The videotape playback and the helpful rating feedback of the other participants will enable you to sharpen your skills in a low risk, high support environment.

NOTES

PLANNING AND STRUCTURING THE TUBERCULOSIS INTERVIEW

OBJECTIVE

Participants will be able to prepare an interview outline applying the planning steps and the master parts of an interview.

An interview in the health care system is used to establish communication between a health care provider and a client. The basic the purpose of the communication and relationship which develops is to restore the client's health, decrease risk, or prevent disease and disability. The interview is a mechanism through which the health care provider obtains information, provides information, gives help and counsel, and teaches. In the tuberculosis control program, the interview is a strategic mechanism for educating and motivating the patient to comply with therapy and followup recommendations and for structuring contact investigations. The interview is a very powerful tool in tuberculosis control. If performed correctly, it can enhance operations which are aimed at achieving the objectives of the program.

The system in which tuberculosis interviewing operates is a composite of health care providers, agencies, and institutions--both public and private--which contribute to tuberculosis control by engaging in specific treatment, prevention, and case finding activities. Finding cases and stopping the spread of infection and disease are the principal features of tuberculosis surveillance and containment. Stopping transmission of infection and disease depends heavily upon educating and motivating the patient to comply with therapy and followup recommendations. Ensuring that contacts of newly diagnosed cases are identified, located, referred, examined, and evaluated for preventive therapy is also essential to tuberculosis control. Traditionally, this responsibility has rested with the health department. One method of identifying contacts is the patient interview. Other methods, such as visiting the home, workplace, or school of the patient to assess environmental air factors, are also used in conjunction with the interview to develop and structure the contact investigation program.

We learned earlier that the success of tuberculosis control activities is directly related to our establishing and maintaining mature and positive relationships with TB clients. The major vehicle for conducting this relationship with a patient is the interview. An interview is not a casual, impromptu speaking situation. On the contrary, it is a situation which requires considerable planning. The lack of adequate planning is one of the greatest weaknesses of this form of communication. For the interview to be successful, the interviewer must have a clear understanding of the objectives of the interview, develop a plan for attaining the objectives, and structure the interview so as to successfully impart to and gain from the patient the desired information.

There are at least five basic conditions for effective interviewing which the interviewer must be certain are met. Disregard for any one of these will

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diminish the effectiveness of the interview. The conditions, which are self-explanatory, are:

1. Arranging for privacy;

2. Creating an environment free of distractions and interruptions;

3. Establishing rapport with the patient;

4. Listening attentively to the patient;

5. Being objective and unemotional.

We can be sure we are meeting these conditions in our interviews if we consistently apply the principles of communication covered earlier in the course.

The success of every interview is governed as well by the interviewer's careful attention to details. Some of the most important and practical are:

1. A clear understanding of the objectives of the interview by the interviewer;

2. An atmosphere (created by the interviewer) which allows (encourages) the patient's free expression;

3. A relationship between the interviewer and the patient which is free of value judgments;

4. An on-going assessment of the patient's thoughts and feelings which could adversely affect the interview;

5. An evaluation of and response to the patient's needs which are expressed verbally and nonverbally in the interview; and

6. The use of feedback by the interviewer and the patient to arrive at a mutual understanding concerning the benefit of the interview.

Each interview must be regarded as an integral part of the total helping relationship and should incorporate these six principles.

A primary responsibility of the interviewer is to plan for the interview. The interviewer must have in mind what is to be accomplished and how to go about it. This means there must be a detailed formulation of objectives and methods for achieving them. At a minimum, these steps should be taken by the interviewer before inviting the patient into the interview situation.

1. Determine the objective(s) of the interview.

   Have clearly in mind what you intend to achieve through the interview. If the objective of the interview is to give information to the patient, know what it is that you want the patient to

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understand. If the objective is to gain information from the patient, know exactly what information is needed from the patient. The best interviews involve two way information exchanges.

2. Analyze the interview situation.

Anticipate and be prepared to adapt to any factors introduced by the patient which could influence the interview. Will the patient be pressed for time so that the interview must be abbreviated or rescheduled? Does the patient speak a language other than English which would require the interview to be conducted in another language or an interpreter to be present?

3. Decide the strategy for the interview.

Be prepared to literally "conduct" the interview, i.e., to guide the conversation so as to attain the objectives of the interview. The information to be given and obtained should be listed on paper in an orderly sequence. Allocate an appropriate amount of time for "sharing" information with the patient in advance.

4. Anticipate and prepare to deal with resistance.

Resistance can arise if the patient perceives you as a threat to his/her ego, safety, or status within a group. Resistance can also develop if the patient reacts negatively to your personality, approach, or official status. The best way for you to anticipate potential patient resistance is to mentally identify with the patient. Put yourself in the patient's place, and try to view the situation from his/her perspective. Resistance can often be avoided or minimized if you pay attention to tactfully opening the interview session. The first few minutes of the interview are critical since it is during this period that you will succeed or fail in establishing rapport with the patient. Resistance that develops during the course of the interview should be handled using the confrontation approach to problem solving.

5. Arrange the timing of the interview.

Schedule the interview for a time when you are most likely to be sure of having the patient's complete attention. The interview should also be scheduled for a time when you can devote complete attention to the patient and the interview.

The importance of planning to the outcome of an interview can not be overemphasized. By taking these steps prior to each interview, you will prevent many problems, and you will be better prepared to deal with any that may surface during the interaction with the patient. One of your principal responsibilities is to ensure that good communication is established and maintained with the patient so that the objectives of the interview will be achieved. Carefully planning the interview is the best way to meet this responsibility.

An interview has four main parts. Think of these as you would an outline for a paper you are writing. They are the introduction, body, conclusion, and followup. Planning and conducting your interviews with this structure in mind gives you an additional advantage in accomplishing your objectives.

Introduction

The introduction is the foundation for the rest of the interview. It is that part of the interview in which you establish a "working" relationship with the patient. This is also where you define the purpose of the interview for the patient. This is a crucial element, because failure in constructing the foundation invariably results in weaknesses throughout the interaction. You must develop rapport with the patient and gain his/her confidence. The introduction should contain dialogue that secures the patient's interest and attention. Some "small talk" (e.g., about the patient's nice appearance, last night's basketball game, the weather, etc.) is appropriate as long as it is genuine and not condescending. Demonstrate that you are a warm, caring person who is interested in the patient. It is also important for you to convey that you have the knowledge and skills to help the patient.

Body

After you establish rapport with the patient, advance to the body of the interview. The body is the part in which you give information to the patient and obtain information from the patient. Several important information exchanges take place: you identify and resolve the patient's concerns; you obtain information needed to structure contact investigation activities; you explain the disease and mode of transmission; you reinforce therapy recommendations; you stimulate the patient to comply with treatment and followup recommendations; you answer the patient's questions; and and you elicit specific names and locating information of contacts. The strategy you have developed for the interview during the planning phase is implemented, and the value of having a clear idea or notes about what should be communicated with the patient becomes vividly clear. You should be flexible enough, however, to depart from a fixed interview outline if it does not seem appropriate with an individual patient.

In most interviews, your chief job is to ask the patient questions. Questions should be asked one at a time. Wait for an answer. If the patient does not respond immediately, resist the urge to move to another question right away. Rephrase the question, if necessary. Sometimes it is appropriate to move on to the next question before a prior question is answered, but the patient should clearly understand that the unanswered question will be presented again later in the interview session. It is best to start with general questions and gradually move to those that are more specific and require more thought by the patient in order to respond.

Conclusion

Terminate the interview only when the objectives have been met. Avoid stopping the interview earlier unless there is reasonable evidence to believe that further communication with the patient at that particular time will not be productive. If you have an agreement with the patient to terminate the interview at a specified time, that agreement should be honored even if the objectives have not been met. In these situations, you must arrange a date and time with the patient to continue the interview. When concluding the interview, be sure to do the following:

- Summarize the main points of the interview;
- Invite the patient to ask questions and answer them;
- Establish a date and time for the next interview (clinic visit, home visit, etc.); and
- Express appreciation for the interview and bid the patient farewell.

Followup

Most interviews need to be followed by a letter, return visit, home visit, or reinterview. This activity is just as important to the success of the interview as the introduction, body, and conclusion. Followup is especially important in monitoring the patient's compliance with therapy recommendations. It is essential if information about contacts turns out to be inaccurate or incomplete.

Finally, for the interview to be successful, it is imperative that you, not the patient, conduct the interview. Loss of control of the interview sends a strong negative nonverbal message to the patient and can result in subsequent problems, including noncompliance, in your relationship. Your command of the interview situation is best accomplished by demonstrating self-confidence, belief in the interaction, and assertiveness and by practicing the principles of communication, including listening, with the patient.

NOTES

DEMONSTRATION INTERVIEW

OBJECTIVE

Participants will be able to rate a simulated interview and provide feedback about its strengths and weakness.

You and the other participants have had varied patient interviewing experiences in your local areas. These experiences may be based on interviewing concepts learned in school, orientation and instruction provided on the job, and self-learning by trial and error. There may be a mixture of perceptions in the class of what a tuberculosis interview session is, and more importantly, when it is done well. These differences will be brought out for discussion, and you will be introduced to new concepts and techniques of interviewing through a demonstration by your instructor. You will use an Interview Checklist to rate the demonstration interview. Be prepared to discuss areas for improvement from which the entire class can learn.

NOTES

PRACTICE INTERVIEWS

OBJECTIVES

1. Participants will be able to conduct an interview using the interviewing format.

2. Participants will receive feedback regarding their interviewing skills.

You and the other participants bring experience and background in interviewing to this course. INTERVIEWING, INVESTIGATING, AND INFLUENCING: APPLICATIONS TO TUBERCULOSIS CONTROL offers you a unique opportunity to actually practice interviewing so you can brush up your skills and gain feedback in a low risk, high support environment. First, in a dyad role playing exercise in which you will interview Jake, our case study, you will be able to practice the concepts and techniques we have covered thus far in the course. Next you will have the opportunity to demonstrate your interviewing skills in a videotaping session. Again, Jake will be the patient. When we play the videotape back, you may critique your own interview and you will receive constructive feedback from the other participants.

In preparation for this session, you should become well acquainted with Jake's history and current tuberculosis status. Study the Expanded Tuberculosis Interview Outline. We will use the format in the practice and videotaping sessions. It is also a good idea to review your notes and the course material we have covered in class.

NOTES

OVERVIEW OF PART III: FIELD INVESTIGATION

The classroom sessions pertaining to field investigation will be conducted as group discussions. You and the other participants will be asked by the instructor to respond to questions and to discuss issues related to the topic. In order to prepare for these classes, read the Participant Guide material and answer the Study Guide Questions. The group discussion will be based to a large extent on the Study Guide Questions. This is your opportunity to share your investigative and outreach techniques with the other members of the class and to learn new ones from them.

NOTES

INTRODUCTION: A QUICK LOOK AT

THE PRINCIPLES OF INVESTIGATION AND REFERRAL
and
WAYS TO PREPARE FOR A TRIP INTO THE FIELD

Implementation of the following four principles will assure your consistent success in conducting tuberculosis field investigations and referrals:

A. Professional Thoroughness: As a health department employee with explicit disease control responsibilities, you must make every reasonable effort to assure that each client is located, referred, examined, and treated. This thoroughness begins with your search of records and locating resources. It means that you must explore all of the realistic avenues available to find clients, motivate them to seek medical attention, ensure that they obtain medical care, and follow up to determine if they are complying with medical recommendations.

B. Promptness: The success of tuberculosis control depends to a large degree on the speed and efficiency with which clients are found, examined, and/or treated. Time, therefore, is critical. You must act promptly whenever clients come to your attention through any program process. Promptness includes the speed with which you take initial action plus your timely and conscientious followup to conclusion.

C. Persistence: You may fail to locate some clients on the first attempt. Others may not respond to your first referral to come to the health department. These clients require more than one investigative action, and you should always be prepared to make the necessary additional telephone calls, visits, and referrals. It is important for you to persist in your activities with any client who is difficult to locate or fails to respond in order to successfully bring the investigation and referral process to a conclusion.

D. Effective Communication: Effective interactions with persons in the field require assertive responses. Effective communication consists of using specific and efficient approaches to providing services and to delivering and obtaining information. The ability to resolve problems which arise when speaking with clients is essential. The best way to communicate with clients and resolve problems is to use open-ended questions to obtain information. Remember that you learn more from clients when they are talking than when you are talking. When you do talk, be direct and brief, and say exactly what you want from the person to whom you are speaking. This requires you to assertively--not aggressively--respond to the situations and people you encounter. You must be able to "sense" problems, even if you follow all the rules of good communication. When you sense a problem is developing, address it then. Don't wait. If you confront potential problems right away, you will prevent later problems which could complicate the field investigation and referral process.

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Most clients will not fully trust you when you first meet them. However, many difficult situations can be avoided if you use open-ended questions. It is sometimes difficult, if not impossible, to recover from a "No" answer to a close-ended question. Develop a discipline to consistently ask open-ended questions in spite of our conditioning to use one way communication.

Expedite your actual field work by undertaking these activities before you go into the field:

A. Organization: Organize your field investigation activities to get the maximum results and to most efficiently use your valuable time. Several factors weigh in your organizational decisions. Setting priorities on each field activity certainly is high among them. For example, on a given day you may be expected to interview a newly diagnosed case for contacts, return a delinquent preventive therapy contact to clinic, provide directly observed therapy to five patients, visit two physicians, and locate three contacts to smear positive cases. You must be able to rank these activities in terms of their importance and carry out your field activities accordingly. You must also consider geography and your advance knowledge about when clients are likely to be at specific locations. Your efforts will be most successful if you organize your work based on priorities and needs, routinely collect detailed locating information from the clients you interview, and obtain from coworkers complete information about clients assigned to you for field activity.

B. Records Search: Clinic medical records and other health department files are valuable resources that can save you significant time and effort in the field. Routinely do the following before going to the field on an initial investigation and referral action:

   1. Check the tuberculosis clinic medical records for locating information or prior visits to the clinic. A contact, for example, may have already reported to the clinic for examination, thus requiring adjustment in field investigation plans. If so, you can save valuable time, not to mention inconvenience to the person.

   2. Check all investigative forms or other records on which field activities are reported. You may have the advantage of a colleague's prior efforts, which might include an appointment to the clinic, and may save the client from feeling harassed or from being referred by two different people.

   3. Check open and closed records of other clinics of the health department to see if the client has received services in the past, such as for family planning, immunizations, etc. These records may contain useful information about the client's medical history and may include the address and telephone number of the client's home or work location.

C. Locating Information: Consult any available source of locating information that is provided by your health department. These can be used to verify questionable information or to supplement the facts you already possess. These sources include:

1. Telephone directory white pages;
2. Cross directory (Haines, Polk, Williams, etc.);
3. Telephone company directory assistance (operators sometimes will confirm or supply an address that goes with a telephone number, or will confirm that a person has an unlisted number);
4. Telephone company security (to obtain an address from an unlisted number);
5. Drivers license bureau;
6. Motor vehicles bureau;
7. Department of public assistance;
8. Utility companies;
9. Post Office;
10. Others provided by your local program.

If you have doubts about the validity of information that is to be sent out of your local area or to another State, check the following sources to verify your information:

1. Long distance telephone information (1 + Area Code + 555-1212). If a charge is billed for this service, check with your supervisor first.

2. Zip code directory (to determine whether the street exists, its proper spelling, and, where supplied, whether the street numbers are valid).

If you are unable to fully verify the information to be sent to another area, be certain to provide as much identifying and locating information that you can obtain in order to facilitate locating and referring the client in the new jurisdiction.

NOTES

OBJECTIVES OF THE FIELD INVESTIGATION

OBJECTIVE

Participants will be able to list objectives of a field investigation.

Regardless of the type of TB clients referred for investigation or other field activity, each investigation has several basic objectives. Some of the most important are:

1. To assure that the client understands the disease which the client has, has been exposed to, or is at risk of having.

2. To assure that the client believes that the information is true and correct and that the client's state of health is a concern of the health department.

3. To assure that the client understands the medical options available to deal with the health problem or risk.

4. To assure that the client is sufficiently motivated to act promptly and appropriately in dealing with the problem or risk.

5. To assure that the client actually responds and receives medical care as a result of the investigation.

STUDY GUIDE QUESTIONS

1. What do we mean by making sure the client "understands the disease"? Give an example of how you can do this.

2. What do we mean by making sure the client "believes the information is true"? Give an example of how you do this.

3. What do we mean by making sure the client "understands the medical options"? Give an example of how you do this.

4. What do we mean by making sure the client "is motivated to act promptly and appropriately"? Give and example of how you do this.

5. What do we mean by making sure the client "responds and receives medical care"? Give an example of how you do this.

6. What kinds of problems have you had accomplishing these objectives with your clients? How did you resolve the problems?

APPROACHES TO THE FIELD RESOURCE PERSON

OBJECTIVE

Participants will be able to discuss how open-ended questions can be deployed as a powerful technique in gaining information from resource persons in the field.

People in some communities are highly suspicious of any person asking questions, especially about how to find someone, and may suspect that you are a threat, e.g., the police, process server, an insurance salesperson, a bill collector, a repossessor, a social services worker, or a probation officer. Some people may even think you are a drug dealer, thief, or criminal. Depending upon the community, the list may include other persons whose presence is not perceived as beneficial for the individual being sought. Your challenge is to interact with the community's residents by being prepared for these perceptions and by using an approach to disarm suspicions and gain the cooperation you need. Remember -- your most important technique in such situations, aside from being sincerely cordial and professional, is to use open-ended questions. A question that allows someone to answer "No" enables that person to avoid involvement, and prevents you from gaining any useable information.

STUDY GUIDE QUESTIONS

1. Why is it important to ask questions in such a way that the field resource person does not answer "No"?

2. What are some of the techniques you use in addition to open-ended questions for gaining information from a field resource person?

NOTES

ENCOUNTERS WITH TB CLIENTS IN THE FIELD

OBJECTIVES

Participants will be able to describe how they will respond to the following challenging situations in the field: (1) identifying the correct person; (2) handling confrontation; (3) communicating with a client when he/she is not at home.

Confirming the Identity of the Client

It is important to assure that you are talking with the right person when you are working with clients in the field. Confirm the client's identity before proceeding. One direct way to do this is to ask. The approach you use when asking is very important. You may be tempted to pose a close-ended question, e.g., "Are you Howard Edwards?" Avoid doing this or you are likely to get a troublesome open-ended question in return, e.g., "Who wants to know?" or "Why do you want to know?" Don't get trapped into explaining or defending yourself at this point to this person who may not even be your client. Instead, take advantage of basic human nature. Most people are inclined to respond candidly when addressed directly, either by their right name or someone else's. Therefore, regardless of who answers the door, quickly say, in the form of a question, the client's first name, e.g., "Howard?" If the person says, "No," respond, "Please let me talk to him a moment." If the person replies, "Howard is not here," ("doesn't live here," "is at work," etc.), followup with open-ended questions. For example, "When will he be back?" "Where does he live?" "Where does he work?" Such questions help you determine where and when it is best to see him. If the person indicates he is at home, be sure to follow your request with a "Thank you." Aside from being polite, it tends to close the conversation and remove the temptation of a curious person to pry into your business. Repeat the first name question when the next person appears. When you get a "Yes", respond with the full name (if you have it), again in the form of a question, e.g., "Howard Edwards?"

Then inform the client about your reason for being there. For example, you may say "I have something important to discuss with you. Where can we talk privately?" The clients you investigate have the right to know precisely why they are being visited. Many of them will already know your visit is related to tuberculosis control; some, particularly suspects and nonfamily contacts, may not know. It is quite logical that they would want this information. Your approach to this is very important. Elect an approach with which you are comfortable and that gets the job done with a minimum of complications. Since the client must first be told about the problem which brings you to the door, the use of one of the following approaches is recommended, although each TB health care provider may use slightly different variations.

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1. The Direct Approach

Using this approach, you explicitly state that tuberculosis is the disease which the client has or has been exposed to. It is the most commonly used approach because it is straightforward and permits you to efficiently lay out what the client needs to do. However, it does have some drawbacks. You may not be able to gauge the subject's reaction to the messages that have to be presented. If the communication is one way, you may have difficulty judging if the client understood the message, appreciates the seriousness of the situation, and is motivated to respond appropriately. Following are examples of the direct approach used with two types of clients.

Nonfamily Contact

(Following a self-introduction) "Mr. Edwards, I came by to inform you that you've been exposed to a serious communicable disease." Pause and then say, "You have been in contact with someone who has tuberculosis. You need an examination for this disease as soon as possible. When can you come to the clinic or go to your doctor's office for a tuberculin skin test?" Depending upon the response, you may then have to ask additional questions. "When did you last have a skin test or chest x-ray?" "When were you last into the health department clinic or at your doctor's office?" "Who is your private physician?" Proceed to explain how you will help to expedite the contact's examination.

Suspect

(Following a self-introduction) "Ms. Capps, I came by to inform you that the tests (chest x-ray or laboratory) you had recently came back positive. The positive result indicates you may have tuberculosis. You need to see a doctor right away in order to determine if you have the disease. When can you come to the clinic or go to your doctor's office?" Again, you may need to ask some followup questions such as "Who is your private physician?" Proceed to explain how you will help to expedite the suspect's examination.

2. The Indirect Approach

Using this method, you make a general reference when describing the risk situation, thereby inviting the client to ask you about the specific disease. This approach lets you control the factors which can compromise a referral using the direct approach. The essential difference comes at the point when you would otherwise get specific. The dialogue with a nonfamily contact (or a suspect) goes something like this:

"Mr. Rice, I came by to inform you that you've been exposed to (that the tests you had recently came back positive for) a serious communicable disease and to help you take care of it."

Pause.

After the client asks, "What disease?" reply: "What do you know about tuberculosis?"

Regardless of how the client responds, you are able to build upon it to motivate an appropriate and timely referral response. First, you have stimulated an early two way communication which involves the client and allows you to judge the reaction. Second, the reply you get can be used to establish either that the client is knowledgeable enough to appreciate the seriousness of the situation--a fact which you reinforce--or is unaware but wise enough to defer to your assessment and recommendations. The client who minimizes the situation can be motivated by pressing for an answer to your question, "What do you know about tuberculosis?"

Responding to Investigative Confrontations of Contacts

You can expect that many contacts, especially nonfamily contacts, whom you inform of a tuberculosis risk are going to express other concerns, make statements, and have questions for which they want answers. The most common confrontations of contacts who do not already know they have been exposed to a case of tuberculosis include:

1. "Do I have tuberculosis?"
2. "I haven't been around anyone with TB."
3. "I feel fine."
4. "There isn't anything wrong with me. I went to my doctor last week and he said I was fine."

Prepare to face any combination or variation of these questions during an investigation and you will find they can be handled smoothly. In fact, you can turn many of these situations to your advantage by convincing the client to act promptly and appropriately. Following are some response patterns that work effectively. Use those which you find suitable to your particular personality and style or develop others with which you are more comfortable.

1. "Do I have tuberculosis?"

   "Not necessarily, but you've been exposed. Not everyone who's exposed gets the disease, but the only way to be sure is to get an examination as quickly as possible. What time today (tomorrow) will you be able to come to the clinic?"

2. "I haven't been around anyone with TB."

   "Tuberculosis germs are transmitted through the air, and you have shared air with a person who has the disease. Your exposure may have been several weeks or months ago, but in no way does this lessen the risk that you face and the need to get an examination as soon as possible. I am concerned about your health, and that's why I'm here. Your health is the most important thing right now, so let's

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talk about getting an examination as quickly as possible. What time today (tomorrow) can I tell the nurses and doctor at the clinic that you'll be in?"

3. "I feel fine."

   "Well that's a good sign and I hope it means everything is ok. But only an examination can tell for sure. Many people can be infected and don't experience any signs or symptoms. If you are infected, the infection could turn into the disease, and the disease is very serious. Now, what time today (tomorrow) can I tell the nurses and doctor that you'll be in?"

4. "There isn't anything wrong with me. I went to my doctor just last week."

   "This disease is rarely discovered by accident. It is hard to detect unless a doctor is looking for it and performs the right tests. Who is your doctor? Why did you go in to see the doctor? What tests did the doctor perform on you, and what treatment was prescribed?" If the history that the contact provides indicates that a tuberculin skin test and/or chest x-ray were done, leave and consult the physician. If not, explain that you will consult the doctor, but that this particular problem was not resolved during that visit. Plan to make another visit to the contact after checking with the physician.

Clinic Referral Slips and Notes

Frequently you will have to leave a written message for your client because you have been unable to talk face to face. Most program areas have a procedure for doing this and a standard clinic referral form for you to use. Some general standards which you should observe are:

1. Avoid mailing a referral.

   This unduly delays the referral. If you have a mailing address, you also have an address for a personal visit. Use the mail only under very unusual circumstances when it will speed up the referral process.

2. Repeated written messages should be used only in conjunction with other strategies. Some people will not respond until several messages are left or attempted visits are made.

   Explore other avenues to actually contact the person, e.g., going by at different times, determining where the client works, identifying a friend or relative through whom to get the message.

3. Always enclose the referral slip in a sealed envelope.

   This helps to protect confidentiality.

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4. Always use a plain envelope and mark it "Personal."

   A business envelope is a sure way to violate confidentiality. An envelope marked "Personal" tends to discourage prying by those for whom the message is not intended.

5. Always leave a note rather than a clinic referral slip whenever confidentiality is an obvious problem.

   Your name and phone number on a note with a request to call you about a personal matter will minimize problems for your client if anyone else is apt to open the envelope and read the contents.

STUDY GUIDE QUESTIONS

1. Why is it important to make sure you are talking with the right person when you are in the field?
2. What problems have you had as a result of speaking with the wrong person?
3. What do we mean by the direct approach?
4. What do we mean by the indirect approach?
5. What do you do when you find the client is not at home?
6. How do you leave a written message?

NOTES

FINDING PEOPLE WITH QUESTIONABLE ADDRESS INFORMATION

OBJECTIVE

Participants will be able to state the course of action to be taken for locating people with an uncertain, incomplete, or inaccurate address.

Often you will have an uncertain address, an incomplete address, or one which turns out to be bogus. You can take the following actions to locate the client:

1. Check the names on the outside of mail boxes in the area.
2. Check the houses or apartments on either side of the given address.
3. Transpose the address numbers and/or the directional prefixes within reason (e.g., 358 to 853, north versus south).
4. Check hospital/clinic records.
5. Talk with next of kin.
6. If contacts, go back to the source case.
7. Find a telephone and call the client.
8. Ask people who may be willing to help.

Certain people you encounter in the field can be particularly informative. Think of them as field resource persons. Consult with them during the course of a difficult investigation. They include:

1. The mail delivery person.
2. Neighbors.
3. Neighborhood "leaders."
4. Apartment managers or supervisors.
5. People congregating in the area, including children at play.
6. Employees of local area small businesses.

It is also helpful to obtain from the client or resource person a description of the house or apartment building and detailed directions for how to get there. Frequently these descriptions and/or directions will enable you to locate the person even though you may have an inaccurate or incomplete address.

STUDY GUIDE QUESTIONS

1. What do you do when you are looking for someone in the field and you discover you have been given an inaccurate or incomplete address?

2. How can it help in doing a field investigation to have a description of the house or building the client lives in? Give an example.

3. What are some other special techniques for locating people with uncertain, inaccurate, or incomplete addresses?

APPROACHES TO THIRD PARTIES

OBJECTIVE

Participants will be able to practice interacting with clients, their families, friends, and coworkers under challenging circumstances.

Often you will have to go through a third party to locate your client. Typical situations which involve a third party are: (1) when you have limited locating information for your client, and (2) when someone else answers the door. Third party confrontations have the potential for problems, unless you are prepared to handle them professionally. Following are three basic categories of third parties whom you may encounter and workable approaches to consider.

The Cooperative Related Third Party

Whenever you must talk with a relative in order to locate the client, your first concern is to determine if the relative has any knowledge about your client's tuberculosis situation. This has to been done in a manner that does not jeopardize confidentiality. Carefully phrased questions and good listening on your part are the keys. If the relative is aware, you need not be concerned about confidentiality issues.

If, however, the relative is unaware but appears to be cooperative, you should offer a reasonable explanation of who you are and what you want. Typical explanations include: (1) you need to see the client about a personal (or business) matter; (2) you are from the health department and have some information to relay; or (3) you are delivering a message. Depending upon the circumstances, a variety of other explanations can be used.

> Note: If the referral information or your observations suggest that the third party to whom you are speaking may also be at risk for tuberculosis, be prepared to refer that person into the clinic for an examination.

The Uncooperative Related Third Party

Sometimes this type of individual presents an obstacle to making contact with your client by denying you entry, refusing to get the person for you, or not saying if the client is or is not there until you explain your business to their personal satisfaction. The tip-off is their use of open-ended questions that were cited earlier, e.g., "Who are you?" and "Why do you want to see Burgin?" Your approach must be cordial but assertive and never defensive or explanatory. Avoid answering the question, other than stating your name, and restate what you want.

"I need to see him about a very important personal matter." If the third party volunteers knowledge of the client's tuberculosis risk, you can proceed to talk about tuberculosis. On the other hand, if you determine the third party does not have this knowledge, you should follow your first sentence with "If he wants to tell you about it, that's his business; but I can only speak with him about it. Please tell him I'm here."

The Non-Related Third Party

You usually encounter these individuals in the client's work place or at "hang-outs" which the client is known to frequent.

1. The Work Place

   If the client is a diagnosed case, chances are good that management staff and coworkers know about the situation. Many of them may have been identified and examined as contacts. If so, you can usually speak openly, but you should remember that the client is an individual and your business is with him/her. However, some cases may not have contacts at work. Other clients, such as contacts, directly observed therapy patients, and persons on preventive therapy, may not want their employer to know about their tuberculosis situation. If the client is out, arrange to call back or go by when he/she is in or leave a number for the client to return your call.

   When you contact the client through a supervisor or coworker, you should telephone first. Ask for the client by name, and say simply that it is an important personal matter and that it will take only a few moments. However, some companies have a policy that no calls to employees are accepted at any time. In this event, you may leave your name and number. If you decide to visit the work place of the client, do so as informally as possible. Go directly to where you can expect to find the client and ask someone where you might find him/her. If you must explain your purpose to a manager, say only that it is an important personal matter and that you will be very brief. Your alternatives are to wait for lunch or quitting time to meet the client as he/she is leaving. If you have a description of the client's car, you may be able to locate it in the parking lot and leave a message or meet the person at the car.

2. Hang-outs

   The key to success with this type of investigation is to find a third party such as a bartender, waiter or waitress, or other patron who can help locate and deliver a message to the client. There is an advantage in initially gaining the confidence of these persons. The approach to be used here might go something like this: Identify yourself and say, "I work for the health department, and I need your help. You see a lot of people from day to day and you get to know a lot of them. I need to get a message to someone who comes here from time to time as soon as possible. You may know this person, but I'm sure that if you don't, you can ask around without anyone becoming suspicious." If the person agrees to help you, share the name and identifying information you have for the client. If the third party knows the client, he may also know where the person lives or works. If he says he might be able to find out, or if he thinks he'll see him/her or can transmit a message, try leaving a note (in a plain sealed envelope) with the third party to be handed to the client. It may be advantageous to telephone this source the next day and see if the note was delivered.

STUDY GUIDE QUESTIONS

1. What should you do if you suspect that the third party is also at risk for tuberculosis?

2. When you visit or telephone a client's work place, how do you go about approaching third parties?

3. If the only locating information you have is a bar or hangout, who would you ask for information or help and how?

NOTES

USE OF THE TELEPHONE IN FIELD INVESTIGATIONS AND REFERRALS

OBJECTIVES

1. Participants will be able to describe how the telephone can be a useful tool in field investigations.

2. Participants will be able to practice handling difficult telephone conversations.

3. Participants will receive feedback regarding their telephone skills.

The telephone is an extremely useful investigative tool. With it you may contact five or ten people in the time it would take you to visit just one person. You may be able to avoid unnecessary conflicts with third parties by calling. Although you can be much more efficient by using the telephone wisely, you must realize its limitations.

It is imperative that you have clearly in mind what you wish to communicate before you pick up the phone. When making calls, it is equally important to have a clear conception of what you intend to accomplish. When you speak with a person, you should first--and most importantly--confirm that the individual on the other end of the line is the client. The next step is to confirm that the person is free to speak about an important private matter. It should be clear that any information which is peculiar to the person could be a good item of identification, especially age. Listen carefully to what is said and the manner in which it is said. If you sense a continued hesitation to engage in the conversation, it could be that the person is not the client you are seeking. In this situation, set up a face-to-face meeting and do not attempt to pursue the matter further over the phone. If the correct person is identified and refuses a face-to-face meeting, insisting the matter be settled over the phone, you may have to inform him/her of the situation and indicate what the person should do, e.g., come to the clinic for an examination or to see the doctor. Avoid a lengthy discussion of exposure details over the phone. Explanation of exposure should be done in person in the clinic or in a face-to-face meeting in the field so that the client may ask questions and discuss concerns in confidence. If you should happen to get a third party who seems to be unwilling to cooperate or who is trying to find out exactly why you are calling, explain that it is personal. If this is to no avail, hang up and try again later in the day or that evening. Do not repeat unproductive telephone calls. Go into the field.

You also receive calls from clients. Many of these calls are the result of your field investigations and referrals. When the caller indicates that he/she has just received a message from the health department about coming to the clinic, ask the person to hold for a moment while you pull the form or record which will allow you to talk to the caller with full knowledge of the situation. Your purpose should be to refer the person to the clinic for examination or treatment as soon as possible--just as if the individual was a client that you had located in the field. If the caller is a coworker's client, you should leave a message for the coworker which is clearly written and includes:

1. Your name/worker number.
2. Date of the message.
3. Time the call was received.
4. Name of the caller.
5. Correct address and phone number, if different than on the form or record.
6. Where the client can be reached at the moment and how long he/she will be there.
7. Where the client can be reached later in the day and when he/she will be at that location.
8. A telephone number at which the client can be reached.
9. Whether or not the client was going to report today for examination or treatment, and if so, where.
10. Any other information that the caller wished to leave.

You should realize that many clients will be irate or in some way disturbed about the fact that they have been contacted by the health department. Be prepared to deal with these people and convey to them that you are concerned and that it is important for their health that they follow through with the referral. Usually at this point the client needs to be assured that the matter can be taken care of quickly and easily and that it is in his/her best interest.

STUDY GUIDE QUESTIONS

1. How can you save time by using the telephone?

2. What would you say over the phone to a newly exposed contact?

3. What would you say to a patient on treatment who has failed to show up for an appointment?

4. What kind of information should you write down as a record of the phone call?

5. What kinds of problems have you had in using the telephone to talk to clients or in taking messages? What are some reasonable solutions to these problems?

NOTES

SAFETY IN THE FIELD

OBJECTIVE

Participants will be able to list at least five principles for assuring greater safety for public health workers in the field.

REQUIRED READING

Lewis ID, Hallburg JC. Strategies for safe home visits. Urban health. 1980.

Due to the nature of conducting investigations in the field, you will be exposed to situations which may threaten your safety. Planning and advanced preparation are just as important in preventing dangerous incidents as they are in other aspects of your job.

In this session we will review a spectrum of situations which may jeopardize your safety while you are working in the field. It is dangerous to stereotype people in their environments, because trust is such an essential ingredient in successful working relationships. Nevertheless, as a TB health care provider working in the field, you need to maintain a balance between trust and awareness. Street-smart public health workers are confident on the streets of the communities they work, and are also aware of potentially dangerous situations. It is important to rely on your own sense of survival, and to avoid the situations which may become harmful.

Spend a little time preparing for this session by identifying potentially harmful categories of persons, locations, situations, and times of the day. Give extra attention to why each factor (on its own or in combination) can create a dangerous situation for you.

STUDY GUIDE QUESTIONS

1. When were you last in a situation that could be defined as harmful or dangerous? Write down some of the particulars of this or another dangerous incident to share with the class. How could you have prevented the incident?

2. What forms of protection or assistance do public health workers have available to them?

NOTES

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Strategies For Safe Home Visits

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Traditionally, the needs of chronically-ill patients, especially those in urban, poor areas, have been served largely by well-educated and highly skilled public health nurses and visiting nurses. Today this is no longer true. Cost containment, technological advances, changes in illness and health care, and an increasingly larger population of older citizens have all contributed to a rapid increase in the number of "new providers" of community health care.

Today, novice nurses, "new non-traditional" health workers, and data collectors are more and more frequently providing services in communities unfamiliar to them, particularly poor, urban residential areas. To aid in the protection of these health workers as they encounter potentially dangerous settings, this article discusses basic assessment skills and identifies some preventive strategies for use when threatening or potentially threatening situations arise.

The influx of "new" health workers includes undergraduate nursing students who are not being trained as public health nurses, as well as home health aides, community health workers, clinical pharmacists, graduate students doing research in health, and others. Such an influx has come in part as a result of recent emphasis on ambulatory care and active outreach programs designed to assist the chronically ill in managing their regimen.

The assessment techniques and tactics presented here are based upon data drawn from interviews with competent public health nurses and experienced nurse researchers. Both groups of nurses employed these skills and tactics in the absence of a two-way communication system (e.g., beepers, or two-way radios) between themselves and their agency.

AT-RISK SITUATIONS

Although there are many possible "at risk" situations in home visits, we have chosen to limit our description to three types in which the personal safety of a home visitor may be in jeopardy. These situations may or may not be mutually exclusive. (1) Home visits to single-room occupants (SROs) in an area with a highly transient population where drug and human abuse are not uncommon, e.g., San Francisco's Tenderloin district; (2) Home visits to a community that differs economically, culturally, and ethnically from the visitor's community, e.g., a white middle-class visitor in a black lower-class community, or an Asian middle-class visitor in a white lower-class community; and (3) Home visits by an inexperienced visitor whose purpose is to collect information and whose patient is an experienced and mature person, e.g., a clinical pharmacists's visit to make a pill count or take blood pressure reading, or a novice researcher's visit to conduct an interview.

Given these three general "at-risk" conditions, several basic assessments should be made by a "new non-traditional" worker. First should be the collection of as much recent data as possible regarding the physical status of the district prior to the home visit. Data should be collected from as many varied sources as possible within a realistic time frame. The worker should also consciously assess her/his feelings and beliefs, and consider any past experiences under conditions similar to those expected to be encountered during the visit.

Let us now consider a high-risk district with a history of transient residents, where many SROs live and where there are subcultures of low socio-economic status amid evidence of drug abuse. What must a worker consider within the parameters of an adequate assessment?

ASSESSMENT OF LOCATION

Begin by asking co-workers, supervisors, instructors, and others to describe the district in which patient resides. Then locate the patient's address on a city map. Inquire about previous outcomes and experiences in this district and adjoining districts. When approaching the neighborhood, note the physical appearance of buildings surrounding the residence of the SRO, and evaluate the physical appearance of the SRO's residence. Has it been recently painted? What is the condition of the doors and windows? What is the general appearance of the street and grounds in front of and near the patient's residence? Are they neat and orderly?

Once inside the patient's residence note whether the outside door of the building is "open to the public," or whether there is some measure of controlled access. If it is a hotel or rooming house, observe the presence or absence of a desk clerk on duty in the lobby. Is there a sign-in and sign-out book at the clerk's desk? Observe the presence or absence of people in the lobby. If present, what is their appearance, and what are they doing? What general age and sex are they? What does the lobby look like? Are there doors? What do the doors suggest? Note the means of access to upper levels. Is it via stairs, elevator, or both? What is the visibility from inside the elevator or on the stairways?

SELF-ASSESSMENT

It is important for the worker to be aware of her/his own role and contributions to any given situation. Prior and existing values, mores, beliefs, and involvement in similar experiences do impinge upon the interaction of comfort, discomfort, and sense of vulnerability in any given setting. This demands an objective assessment of feelings and capabilities by the worker.

An inexperienced worker may be unfamiliar with the norms, social distancing, social interaction patterns, and jargon of the patient, and thus misread the patient's communications. Therefore, to ensure the visit's safe outcome, the worker may need to lay some ground rules or set the stage to seek clarification at the outset of the visit. In this way, the worker is being fair and "upfront" with herself/himself and with the patient.

PATIENT ASSESSMENT

Prior to making the visit, read the patient's chart, if available, for pertinent background; e.g., history of alcohol or other drug abuse, source of income, age, birthplace, ethnicity, educational level, etc.

Once inside the patient's room, note its general appearance. Is it neat, or is it disarrayed? Note the presence of any odors, beer cans, or alcoholic bottles. Observe the types of pictures on the wall, if any. Note the location of exits from the room. Make an assessment of the patient's dress, e.g., pants and shirt, or undershirt and pants, etc. Note also patient's general personal appearance and body hygiene. Finally, observe where the patient sits and where she/he suggests you sit.

PREVENTIVE TACTICS

Now, let us consider preventive tactics which a worker may use to maximize safety of a home visit. Again, an at-risk setting is suggested in a district where people on the streets exhibit atypical behavior and unpredictable actions, e.g., shouting at passers-by or moving their hands in a boxer-like manner while walking down the street, or others who just seem to "hang out" on streets where many businesses are boarded-up.

PREVENTIVE TACTICS

An excellent strategy to assure a safe home visit is to plan for it well in advance. Here are some suggestions others have found useful: (1) Make certain you have established a goal or goals for the home visit. Plan to make your purpose clear and precise at your arrival. (2) Plan an early morning visit, e.g., 9:00 - 10:00 a.m., to get into and out of the district prior to the gathering of many of the "street people." Evening visits should be made by two persons. (3) Engage in a role-playing exercise in which one worker plays herself/himself, and another plays the patient. Practice what not to say, as well as what to say, and how to act versus how not to act. (4) Establish an "alerting system," and pre-plan the length of your visit. Arrange to check with someone before and after an "at-risk" home visit. For example, a worker can telephone the office 5 to 10 minutes before and after such a visit.

There are also guidelines which should be followed upon arrival at the patient's residence. Leave unnecessary items in your car, and put valuable items out of sight **prior to** parking in the district. When on the streets, carry items close to the trunk of your body. Hold an item such as a shoulder bag with one hand. Place your hand on top of or about the bag and press it against your body. Carry your tape recorder, blood-pressure kit, or other equipment in a similar fashion – always close to your body.

Once inside the patient's residence, rest your handbag or other item upon your lap, or rest it against your feet. Sit only in a chair, preferably facing the patient. Do not sit upon the bed.

Inform the patient of your time schedule early in the visit. Adhere to your time plan with a five to ten minute flexibility.

If uniforms are not required, do not wear casual clothes, e.g., blue jeans. Instead, wear a suit or daytime dress with stockings and dress shoes. Use a mild perfume or cologne, if any. This attire connotes a businesslike interaction. If the nurse wears casual attire, the patient may perceive that a non-businesslike interaction is appropriate to pursue. On the other hand, overdressing might also be perceived by the patient as basis to pursue a non-businesslike interaction.

If the planned visit is an evening one, then visiting in pairs is recommended. Use of an alerting system immediately before and after the encounter is also important. Planning the visit so that each health worker can learn from the experience should be a prearranged goal and outcome.

If transportation is by car, park under a street light. Don't open the car door is a person is approaching, or has just passed. Instead, wait till all persons are 50 yards or more away from the car. While seated inside, keep the doors locked. Use the same caution when returning to the car to re-enter and exit from the area. If transportation is by bus, plan to make any and all transfers in well lighted, less "at-risk" communities, even if such precautions make the ride longer.

ABORTING A "SOUR HOME VISIT"

Here are some simple tactics to assist in the exit from perceived unsafe situations. Once inside, a home visitor has to assess, plan, act, and react in an ongoing, dynamic way.

Use of the self is key when confronted with these risky conditions. If the patient who welcomes you is not dressed in street clothes and is of the opposite sex, wait at the door and request that the person dress prior to your entry.

Once you are inside, if the conversation is frequently redirected from your stated purpose, persist with a brief, but focused, explanation of your mission. If this approach fails, then explain your intent to leave and proceed to do so. Make it very clear that you are expected in your office to meet with a specific person within 15-20 minutes. Be firm and avoid displaying any evidence of fear, e.g., voice changes, hands shaking, etc. Always be firm, and make slow, yet deliberate movements toward the exit.

"New non-traditional" health workers must be aware of the explicit, yet subtle cues in high-risk home-visit situations that more experienced community health workers have long known. These "new" health workers should also possess a repertoire of preventive tactics from which they can draw when necessary to help ensure their own personal safety in high-risk situations. If home visits actually do become unsafe, health workers need to know a series of pragmatic steps to take, in order to extricate themselves safely from any threatening situations.

REFERENCE

Lewis, I.D.: *Management of Chronic Hypertension by Black Clients.* Unpublished Doctoral Dissertation, University of California at San Francisco, 1978.

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DOCUMENTATION

OBJECTIVE

Participants will be able to document on the appropriate forms the work performed on an investigation and referral.

The purpose of documentation is to record facts about a particular investigation or field visit. Documentation is also necessary in order to maintain information about the client's referral that may be useful in the future, if the client should require another investigation or visit. In addition, documentation allows others to continue investigative activities in your absence. To efficiently document events, make specific notes as soon as possible after the event. These should include the date, time, and each specific action you took, plus the response of the other person(s), commitments made by either party, expectations you held, the nature of the situation, and recommendations for future action. Above all, documentation must be legible and should identify you, by name or worker number, as the health care provider responsible.

Use abbreviations or any other form of communication that permits you to record (and coworkers to read) the message in an efficient manner. Whatever method used should be universally understood by all members of the staff. Learn the documentation requirements of you own program and the standard or commonly understood abbreviations, e.g., FV = field visit, TC = telephone call, NA = no answer, etc.

> EXAMPLE: You searched for an assigned delinquent therapy patient in the medical records and case register, the cross directories, and the telephone directory on 7/31/87. Then you immediately called the home phone number and it was busy. An hour later you called the home number again and no one answered. You phoned the work number and it was disconnected. Before you left work, you called the home number again and someone answered. When you asked for Burgin, the person on the other end of the line hung up. You went on a field visit the next morning and no one answered the door, so you left a referral note on the door. You then drove past the house at noon and saw no one at home, but talked to a neighbor who confirmed that the person lived at the address.

One typical way of documenting these events is as follows:

7/31/87 RS --MED REC / CS REG / X DIR / TEL DIR - ADDRESS/TEL NO CONFIRMED

7/31 9:30 AM TC (HOME) - BUSY

7/31 10:30 AM TC (HOME) - NA

7/31 4:30 PM TC (HOME) - SOMEONE ANSWERED, BUT WHEN I ASKED FOR BURGIN
THEY HUNG UP

7/31 4:40 PM TC (WORK) - DISC

8/1 9:00 AM FV - NO ONE HOME - LEFT REFERRAL

8/1 12:00 PM FV - NO ONE HOME - SPOKE WITH MARTHA PHILLIPS NEXT DOOR
WHO CONFIRMED THAT BURGIN LIVES AT THE
ADDRESS AND IS USUALLY HOME FROM 7:00PM
UNTIL 7:00 AM EACH DAY

Good documentation permits you to use your investigative time efficiently, make better decisions, and improve communication with coworkers. The activity you most frequently document is the work associated with an investigation. For yourself, the notes are your guide concerning what to do next. If you become ill or if you must put one investigation aside to do higher priority work, the notes will immediately remind you or tell a coworker the status of the investigation. If a particular investigation must be transferred to another jurisdiction, the notes will enable the health department staff member who is assigned the investigation to begin where you left off rather than starting over again.

STUDY GUIDE QUESTIONS

1. Why is documentation of investigations and referrals necessary?
2. What type of system do you have for recording investigations and referrals?
3. How do you document your field work?
4. What kinds of problems or barriers keep you from making notes?
5. What are some examples from your experience of how good notes helped an investigation?
6. What are some examples of how lack of notes hindered an investigation or referral?

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APPROACHES TO PRIVATE PHYSICIANS

OBJECTIVE

Participants will be able to describe at least one new strategy for attaining information from private physicians.

There are many situations in which you need to call upon a private physician:

1. Following up on positive laboratory reports or case reports generated by the doctor.
2. Informing a doctor that a contact has indicated he/she will go there for examination, letting the doctor know what disease is involved, and guiding him/her to be prepared to do an appropriate examination.
3. Obtaining treatment and/or followup information about a diagnosed case under the doctor's care.
4. Verifying information a client has given you about examinations or treatment by a doctor.
5. Providing feedback to the doctor about health department actions with clients who are his/her private patients.

When you call or visit a private physician about a positive smear or culture report which was reported to the health department by a laboratory, confirm that the specimen was actually submitted from that office. For example, following a self-introduction, identifying the patient and the date and type of test involved, state, "Doctor, I would like to confirm that this is your patient and to inform you of these results, if you have not yet received them." Assuming that the doctor confirms that the person you are talking about is his/her patient and that the specimen was obtained on that date, determine the status of the diagnosis and treatment. Ask if the doctor plans to treat and follow the patient or if he/she prefers to have the health department do this. If the doctor plans to treat, find out if the patient will be coming to the health department for other services, e.g., drug refills, sputum examinations, x-rays, etc. Explain that the health department will be doing contact investigation which involves an interview of the patient and a home visit. Inform the doctor that you and other health department staff are available to ensure that the patient returns for followup and remains current on drugs. Determine if the doctor needs assistance in any other aspects of managing the patient, and make the appropriate arrangements. Leave your name and telephone number with the doctor.

The procedures discussed above can also be used when contacting a physician who sends a report card for a newly diagnosed case to the health department.

The first telephone call or visit to a physician about a patient is very important in setting the stage for successful followup visits and calls. Inform the doctor that you or a coworker will be contacting him/her periodically during the course of treatment for updates of the patient's status. At those times, the health department will be interested in getting information about the regimen, the patient's compliance, and bacteriologic and x-ray status. Offer to share the results of contact investigation with the physician.

If a private physician's patient is being treated and followed for tuberculosis at the health department, it is always a good idea to keep the physician informed about the patient's progress. If you are called on to do this, brief visits or telephone calls should be made at times convenient for the doctor.

Some patients may be hospitalized when you receive the laboratory or case report. Identify the patient's physician and contact him/her as discussed in the preceding paragraphs. It may be necessary to talk with hospital staff, such as the laboratory director or the infection control nurse, in order to get the information you need about the diagnosis and treatment, plans for continuation of treatment and followup, and initiation of the contact investigation. Approaches to hospital personnel should be handled with the same commitment and professionalism as those you use with physicians in their private offices.

STUDY GUIDE QUESTIONS

1. What situations in make it necessary to contact a private physician?

2. What are some effective strategies for obtaining private physicians' cooperation?

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